Los Alamos Public Schools
"We prepare confident, life-long learners."

Kindergarten Health Examination by Physician

School child will attend: ______________________________

Student ____ School Year ________________
Last First MI

Birth Date ____/____/______ Gender ☐ Male ☐ Female

Parent/Guardian: ____
Last First Relationship

Home Phone # ________________ Cell Phone # ________________ Work Phone # ________________

Physician: ________________________________ Fax # ________________ Phone # ________________

SUMMARY OF PHYSICIANS EXAMINATION

Note to Physician: The information requested below will assist the schools in meeting the child's individual needs.

Vision	Color Vision	Audio

Please check "Yes" or "No" and specify recommendations:

☐No ☐ Yes	1. Are there any delays in speech/language development?
☐No ☐ Yes	2. Are there any disabilities that would limit participation in school activities?
☐No ☐ Yes	3. Are there conditions which could cause classroom emergencies, (e.g. seizure disorder, diabetes, fainting, allergies, asthma)? Circle those that apply
☐No ☐ Yes	4. Does this child have any other medical problem with which the school should be concerned?
☐No ☐ Yes	5. Is the child currently taking any long term medication? If yes, name of medication:______________________________

Physician's recommendation to the school: ____

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Please attach a copy of the immunization record to this form.

______________________________ ________________
Signature of Physician Date

Los Alamos physicians: Please keep these forms until called for by the school nurse

Other physicians
Mail the form to:
Los Alamos Public Schools,
Attention Student Services
P.O. Drawer 90
Los Alamos, NM 87544

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Date Received

5141R Health Examinations and Immunizations Addendum 2 Kindergarten Health Examination by Physician
(Revised 03/2015)