SCHOOL DISTRICT OF CADOTT COMMUNITY

Kindergarten Medical Examination

(Note: This is not necessary for 5K if it has already been completed for 4K.)

Health Care Provider please fax: **(715) 289-3017** to school before Sept. 1 of this year**.**

Student_____ ________________________Parent/Guardian________________________

Doctor______________________________MD Phone____________________________

This child has a history of the following:

Seizures   Serious Illness or Injury   Surgery   Head Injury   Ear Infections
Chickenpox   Strep Infections   ALLERGIES   Tuberculosis Exposure   Rheumatic Fever
Respiratory Disease   Diabetes   ADD/ADHD   Heart Disease   Kidney Disease

*Explanation*____

Height__________Weight___________   Urinalysis_______Blood work________

General	Healthy	Needs Further Evaluation	
Skin	Normal Abnormal	Lesions	
Ears	Normal Abnormal	Hearing Loss	right___left___
Eyes	Normal Abnormal	Vision	right___ left___
Tonsils	Normal Abnormal	Absent	
Neck	Normal Abnormal		
Heart	Normal Abnormal	Murmur: Benign	Pathological
Lungs	Normal Abnormal		
Abdomen	Normal Abnormal	Hernia	
Extremities	Normal Abnormal		
Neurological	Normal Abnormal		
Spine	Normal Abnormal	Scoliosis	

Disabilities: None developmental orthopedic vision hearing learning behavioral other

Comments: ____

Immunization(s) given at time of exam: ____

(Or attached updated immunization record)

Please print health care provider name or use health care provider stamp.

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Health Care Provider Signature/Date