St. Patrick of Heatherdowns Health Record (Cont.)

Physician's Report

Child's Name: _____ Age _____ (years) _____ (mos.)

Immunizations: **(Pre-Kindergarten)** 4 DPT, 3 Polio, 1 MMR, 3 Hepatitis B, 4 HIB, 1 Varicella
(Kindergarten) 5 DPT, 4 Polio, 2 MMR, 3 Hepatitis B, 2 Varicella

DPT 1_____ 2_____ 3_____ 4_____ 5_____

Polio 1_____ 2_____ 3_____ 4_____ 5_____

MMR 1_____ 2_____

Hep B 1_____ 2_____ 3_____

HIB 1_____ 2_____ 3_____ 4_____

Varicella 1_____ 2_____

Other Type _____ date _____ Type _____ date _____

Screening Tests:

Vision (pass / fail):
Distance Acuity R _____ L _____
Muscle Balance R _____ L _____
Farsightedness R _____ L _____
Color (Circle) Pass / Fail
Wears glasses Yes / No
Referral made Yes / No

Hearing (pass / fail):
Pure Tone R _____ L _____
Impedance R _____ L _____
Frequent ear infections? _____
Does child have tubes? _____
Right _____ (date(s) placed)
Left _____ (date(s) placed)

Physical Exam:

Essentially normal: _____ Abnormalities as follows: _____

_____

Is this child able to participate in all school activities? Yes_____ No _____

If no, please explain: _____

This is to certify that the above named student has been seen in our office and is in suitable condition to attend a preschool or kindergarten program.

(PRINT OR STAMP BELOW)

Signature _____ Physician name _____

Date of exam _____ Address _____

Phone _____ _____