# Indian Valley School District
## Kindergarten Health Screen

Child's full name_____
Last First Middle

male_____ female_____ birth date_____
month day year

Child's address_____

Father's name_____
his address (if different from child's)_____
his work phone_____ his home phone_____

Mother's name_____
her address (if different from child's)_____
her work phone_____ her home phone_____

With whom does child live?_____
name relationship

Who is this child's legal guardian?_____

Please list this child's brothers and sisters:

### FAMILY HISTORY

| | Name | Birth Year | Sex | | Name | Birth Year | Sex |
|---|---|---|---|---|---|---|---|
| 1. | | | | 6. | | | |
| 2. | | | | 7. | | | |
| 3. | | | | 8. | | | |
| 4. | | | | 9. | | | |
| 5. | | | | 10. | | | |

### PRENATAL HISTORY

Did the mother have any unusual physical or emotional illness during this pregnancy?
yes____ no____ If yes, explain briefly_____

How old was the mother when this child was born?_____

Was this infant born: full term_____early_____late_____What was this infant's birth weight?_____

Did the infant have any sickness or problems while in the nursery? yes____ no____

If yes, explain briefly_____

### DEVELOPMENTAL HISTORY

Please give the approximate age at which this child:
walked alone _____was toilet trained _____spoke in sentences _____dressed self _____

How does this child's development compare to other children, such as his or her brothers, sisters, playmates?
about the same_____ slower_____ faster_____

TO BE COMPLETED BY PARENT OR GUARDIAN

I. HEALTH CONDITIONS - Please check any that this child has had:

_____Abnormal spinal curvature, scoliosis, etc.
_____ADHD
_____Allergies or hayfever
_____Anemia
_____Arthritis
_____Asthma or wheezing
_____Bedwetting at night
_____Behavior problem
_____Birth or congenital malformation
_____Cancer, type_____
_____Chicken pox
_____Chronic diarrhea or constipation
_____Concern about relationship with siblings or friends
_____Cystic fibrosis
_____Diabetes
_____Eczema
_____Emotional problems
_____Eye problems, poor vision
_____Frequent headaches
_____Frequent skin infections
_____Frequent sore throat infections
_____Heart disease, type_____
_____Hepatitis
_____Kidney disease, type_____
_____Measles ("old fashioned" or " ten day")
_____Meningitis or encephalitis
_____Multiple ear infections (3 or more)
_____Mumps
_____Near drowning or near suffocation
_____Nervous twitches or tics
_____Poisoning
_____Poor hearing
_____Pregnancy
_____Rheumatic fever
_____Seizures or epilepsy
_____Sickle cell disease
_____Stool soiling
_____Substance abuse (alcohol, drugs)
_____Suicide attempt
_____Toothaches or dental infections
_____Urinary tract infection
_____Wetting during the day

II. ALLERGIES - Please list and describe allergies or reactions to:
Medicines, foods, plants, animals, other_____

Recommended treatment if allergy is severe:
EpiPen _____ Inhaler _____

III. INJURIES AND ILLNESSES - Please list any severe injuries or illnesses; extended surgery; head injury; broken bones.

| Injuries/Illnesses | Age of Child | If Hospitalized (check) |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

IV. ADDITIONAL INFORMATION:
What medications are given daily?_____
What medications are given frequently, but not daily?_____
This child is usually: very active_____ normally active_____ rather inactive_____
Do you have any concern about how your child gets along with other children?
_____
_____

V. Do you have other comments or concerns about this child's health, development, behavior, family or home life that you would like the school to be aware of? If yes, explain briefly_____
_____
_____
_____

Completed by:_____ Relationship to child:_____

INDIAN VALLEY LOCAL SCHOOLS
OHIO SCHOOL HEALTH RECORD
PHYSICIAN'S REPORT

Child's Name_____ Male_____ Female_____Age_____ Date_____

OBJECTIVE DATA:

Height:_____( %) Weight:_____( %) BMI:_____ B.P.___/_____

## SCREENING TESTS

Vision Date done_____
Distance Acuity: R_____ L_____
Muscle Balance pass____ fail____ not done_____
Farsightedness pass____ fail____ not done_____
Color pass____ fail____ not done_____
Child wear glasses? yes_____ no_____
Tested with glasses? yes_____ no_____
Referral made? yes_____ no_____

Hearing Date Done_____
Audiometric thresholds:
R - ear pass____ fail____ not done_____
L - ear pass____ fail____ not done_____
Other tests (specify)_____
Child wears hearing aid? yes_____ no_____
Tested with hearing aid? yes_____ no_____
Referral made? yes_____ no_____

## SPEECH /LANGUAGE

Speech assessment: done_____not done_____
Child has no discernible speech problem_____
Child has possible problem with:
Disorders: (check) Articulation_____Rhythm_____Voice_____Language_____
Speech evaluation recommended: yes_____no_____

## LABORATORY TESTS

Hematocrit Hemoglobin_____ Urine protein_____ Urine blood_____ Urine glucose_____ Other_____

PHYSICAL EXAMINATION: Date examined_____ Essentially normal_____ Abnormalities as follows:

Is this child able to participate fully in the following:

A. Classroom and academic activities? yes_____ no____
B. Physical education classes? yes_____ no____
C. Competitive athletics? yes_____ no____
D. Contact and collision sports? yes_____ no____

If limitations are advised, please specify those limitations: _____

If this child has any physical, developmental or behavioral problems, how can the school assist with special programs, placement or attention?

PHYSICIAN'S ASSESSMENT

| Problem List | Recommendation for school management |
|---|---|
| 1. | 1. |
| 2. | 2. |
| 3. | 3. |

PLEASE PRINT OR STAMP

Physician's name _____ Physician's signature _____

Address _____

Phone _____ Date signed _____

Child's Name _____ DOB _____

IMMUNIZATION RECORD

| **Type** | **Date** | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| DTaP/DTP/DT | / / | / / | / / | / / | / / | / / | | | | | | | |
| Tdap/Td | / / | / / | / / | / / | / / | / / | | | | | | | |
| Polio (IPV) | / / | / / | / / | / / | / / | / / | | | | | | | |
| MMR | / / | / / | | | | | | | | | | | |
| Measles (Rubeola) | / / | / / | | | | | | | | | | | |
| Rubella | / / | / / | | | | | | | | | | | |
| Mumps | / / | / / | | | | | | | | | | | |
| Hepatitis B | / / | / / | / / | / / | | | | | | | | | |
| Varicella | / / | / / | | | | | | | | | | | |
| HIB (Prior to age 5 only | / / | / / | / / | / / | / / | / / | | | | | | | |
| Other (Identify) | / / | / / | / / | / / | / / | / / | / / | / / | / / | / / | | | |

INDIAN VALLEY LOCAL SCHOOL DISTRICT
OHIO SCHOOL HEALTH RECORD

DENTIST'S REPORT

The following services have been performed:
_____Examination
_____Diagnosis
_____Radiographs
_____Oral Prophylaxis
_____Prescription for fluoride supplements
_____Topical application of fluoride

The following oral hygiene instruction was provided:
_____Tooth brushing
_____Flossing
_____Diet counseling reflecting relation of diet to dental health
_____Home/school use of fluoride mouth rinse

The following statements are applicable:
_____All necessary services have been performed
_____No restorative services are required at this time
_____Further treatment is indicated
_____Further appointments have been arranged

COMMENTS: _____

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PLEASE PRINT OR STAMP

Dentist's name_____
Address_____
Phone_____
Dentist's signature_____
Date signed_____

CHILD'S NAME_____ D.O.B._____