



PRESCHOOL / KINDERGARTEN MEDICAL EXAMINATION

TO BE COMPLETED BY A HEALTHCARE PROVIDER

Kits4Kids International School Madagascar

STUDENT INFORMATION

STUDENT NAME :	DATE OF BIRTH (dd/mm/yyyy) :
PARENT / GUARDIAN NAME (S) :	SCHOOL ATTENDED :
HEALTHCARE PROVIDER / DOCTOR :	DATE OF EXAMINATION :

IMMUNIZATIONS

Attach a copy of the immunization record.

PERTINENT ILLNESS, COMMUNICABLE DISEASES, RISKS, OR DEVELOPMENT PROBLEMS

Please check all that apply.

<input type="checkbox"/> ALLERGIES <i>If yes, please list:</i>	<input type="checkbox"/> ASTHMA	<input type="checkbox"/> ATTENTION / LEARNING
<input type="checkbox"/> BLEEDING DISORDER	<input type="checkbox"/> CANCER / LEUKEMIA	<input type="checkbox"/> CEREBRAL PALSY
<input type="checkbox"/> CHICKEN POX <i>If yes, date:</i>	<input type="checkbox"/> CYSTIC FIBROSIS	<input type="checkbox"/> DENTAL PROBLEMS
<input type="checkbox"/> DIABETES	<input type="checkbox"/> EMOTIONAL / BEHAVIOR	<input type="checkbox"/> ENCOPRESIS
<input type="checkbox"/> ENURESIS	<input type="checkbox"/> GENETIC DISORDER	<input type="checkbox"/> HEART CONDITIONS
<input type="checkbox"/> HEARING DISORDER	<input type="checkbox"/> HEPATITIS	<input type="checkbox"/> KIDNEY DISORDER
<input type="checkbox"/> LEAD LEVEL <i>If yes, test done: [] YES [] NO At risk: [] YES [] NO</i>	<input type="checkbox"/> OBESITY	<input type="checkbox"/> ORTHOPEDIC CONDITION
<input type="checkbox"/> PNEUMONIA	<input type="checkbox"/> SEIZURE / CONVULSIONS	<input type="checkbox"/> SICKLE CELL ANEMIA
<input type="checkbox"/> SPEECH / LANGUAGE	<input type="checkbox"/> TUBERCULOSIS	<input type="checkbox"/> VISION
<input type="checkbox"/> OTHER <i>If yes, please list :</i>		
<input type="checkbox"/> COMMENTS <i>If yes, please explain all that apply:</i>		

PHYSICAL EXAMINATION

SUMMARY OF FINDINGS

	NORMAL	ABNORMAL		
			HEIGHT : cm	<input type="checkbox"/> WELL CHILD, NO CONDITIONS IDENTIFIED OF CONCERN
GENERAL APPEARANCE	<input type="checkbox"/>	<input type="checkbox"/>	WEIGHT : kg	<input type="checkbox"/> CONDITIONS IDENTIFIED THAT ARE OF CONCERN TO SCHOOL AND / OR PHYSICAL ACTIVITY <i>Complete sections below and explain here :</i>
H.E.E.N.T	<input type="checkbox"/>	<input type="checkbox"/>	BLOOD PRESSURE: /	
SKIN	<input type="checkbox"/>	<input type="checkbox"/>	HEARING : R L	
NECK	<input type="checkbox"/>	<input type="checkbox"/>	VISION : R L	<input type="checkbox"/> INDIVIDUAL HEALTH PLAN NEEDED
CHEST	<input type="checkbox"/>	<input type="checkbox"/>	Optional:	<input type="checkbox"/> SPECIAL DIET REQUEST FORM
HEART	<input type="checkbox"/>	<input type="checkbox"/>	HCT / HGB :	<input type="checkbox"/> PHYSICAL EDUCATION EXCUSE
ABD / GENITALIA	<input type="checkbox"/>	<input type="checkbox"/>	UA :	<input type="checkbox"/> MEDICATION ORDER FORM
MUSCULOSKELETAL	<input type="checkbox"/>	<input type="checkbox"/>	TB TEST <i>Date :</i>	<input type="checkbox"/> ASTHMA MEDICATION ORDER FORM
NEURO	<input type="checkbox"/>	<input type="checkbox"/>	<i>Type :</i> <i>Results :</i>	<input type="checkbox"/> ALLERGY / ASTHMA ACTION PLAN

PROVIDER INFORMATION

PROVIDER'S NAME :	PHONE :
ADDRESS :	CITY : COUNTRY :

PROVIDER'S SIGNATURE

DATE

NOTE: If you wish to save data typed into this form, first save the file on your computer and re-open from your computer prior to typing.