First Name:

Date of Birth:

Fairview Park City School District
21620 Mastick Rd., Fairview Park, OH 44126
p: 440.331.5500 f: 440.356.3545
www.fairviewparkschools.org

Dr. William W. Wagner, Superintendent

Last Name:

Graduation Year:

Student Number:

Document Type:

SCHOOL ENTRANCE MEDICAL RECORD FOR KINDERGARTEN (TAKE THIS TO YOUR PHYSICIAN)

School:____ Grade:______________________________
Name of Child:______________________________________ Birthdate:___________________________
Month Day Year
Address:____

EXAMINATION

Date:_______________________________ Height:_______________________ Weight:_______________
Eyes:_______________________________ Vision: R. 20/__________________ L. 20/_______________

Ears:_______________________________ Hearing Test: Type:_____________ R________L______
Referred to ear/eye specialist? Yes______ No_______
Nose:____ Throat:_____________________________________
Mouth:____ Teeth:______________________________________

Is dental work indicated? Yes_____ No_____ If so, are plans being made? Yes____ No_____
Posture:____ General Condition:_____________________________
Skin:____ Orthopedic:___________________________________
Neck:____ Nervous System:_______________________________
Heart:____ Lungs:_______________________________________
Abdomen:____ Hernia:_______________________________________
Genitalia:____ Urinalysis:___________________________________

Remarks and Recommendations:____
____

IMMUNIZATIONS – (Please give exact dates)

DPT (Diphtheria, Tetanus, Whooping Cough): **5 DOSES REQUIRED** (unless 4th after 4th birthday, then 4 required)

1.____________ 2.________________ 3.________________ 4.______________ 5.______________

Polio: **4 DOSES REQUIRED** (final dose must be administered on or after the 4th brithday)
1.____________2.______________ ___3.________________ 4.______________ 5.______________

MMR (Measles, Mumps, Rubella): **2 DOSES REQUIRED**
1 ____________ (must be given after 1st birthday)
2 ____________ (must be given at least 1 month after 1st dose)

Varicella(Chicken Pox) 2 Doses
1.________2.______

Hepatitis B: **3 DOSES REQUIRED** (2nd dose at least 1 month after 1st, 3rd at least 2 months after 2nd and follow 1st by at least 4 months and not before age 6 months, or a 4th dose is needed)
1.________________ 2.________________ 3.________________4.______________________

Hib: (haemophilus b)______________________________________ Other______________
Latest Tuberculin Test: Type___________ Date__________ Positive______ Negative________

I CERTIFY THAT THIS CHILD HAS HAD THE ABOVE IMMUNIZATIONS

________________________ ____
Date Signature of Physician