Sanford School Department
Kindergarten/Pre-K Screening Medical Form

Student's Full Name:_____ DOB:_____
Parent/Guardian Name:_____ Phone number:_____

Please check yes or no for each question listed below. The answers will be held in strict confidence by the school nurse and physician and will aid them greatly in evaluating your child. You may add comments explaining the yes answers in the area provided.

REVIEW OF GENERAL HEALTH OF THE CHILD: To be completed by parent/guardian

Is your child in good health?	☐Yes	☐ No	Chronic or frequent vomiting	☐Yes	☐ No
Skin Rashes	☐Yes	☐ No	Chronic diarrhea	☐Yes	☐ No
Pale skin	☐Yes	☐ No	Joint pain	☐Yes	☐ No
Easy bruising	☐Yes	☐ No	Constipation	☐Yes	☐ No
Frequent stuffy nose	☐Yes	☐ No	Frequent stomach pains	☐Yes	☐ No
Frequent ear infections	☐Yes	☐ No	Hernias	☐Yes	☐ No
Poor vision	☐Yes	☐ No	Bedwetting	☐Yes	☐ No
Hay fever	☐Yes	☐ No	Frequent urination	☐Yes	☐ No
Nose bleeds	☐Yes	☐ No	Painful urination	☐Yes	☐ No
Cross-eye or squint	☐Yes	☐ No	Swollen glands	☐Yes	☐ No
Teeth cavities	☐Yes	☐ No	Fainting	☐Yes	☐ No
Chronic cough	☐Yes	☐ No	Frequent sore throat	☐Yes	☐ No
Frequent pneumonia	☐Yes	☐ No	Mouth breathing	☐Yes	☐ No
Poor appetite	☐Yes	☐ No	Heart Murmur	☐Yes	☐ No
Limp	☐Yes	☐ No	Weight gain or loss in year	☐Yes	☐ No
Poor coordination	☐Yes	☐ No	Convulsions	☐Yes	☐ No
Fatigue	☐Yes	☐ No	Frequent headaches	☐Yes	☐ No
Behavior problems	☐Yes	☐ No	Recurrent or frequent fevers	☐Yes	☐ No

MEDICAL CONCERNS/COMMENTS:

_____
_____
_____
_____

VISION TEST Pass ☐ Fail ☐
HEARING TEST Pass ☐ Fail ☐

DATE OF PHYSICAL EXAM: _____FAMILY PHYSICIAN:_____

☐ CHECK HERE IF YOU WOULD LIKE A CONFERENCE WITH THE NURSE DURING KINDERGARTEN SCREENING

Updated 4-19-2023