Green Bay Area Public School District
Green Bay, Wisconsin

MEDICAL EVALUATION (required)
EVALUACIÓN MÉDICA (requerida)

This form should be completed for each kindergarten student upon entrance into the Green Bay Area Public Schools.
Esta forma debe completarse por todo estudiante de kindergarten que entra a las Escuelas Públicas del Área de Green Bay.

School *Escuela*____

TO BE COMPLETED BY PARENT BEFORE EXAMINATION BY PHYSICIAN
Esta porción debe completarse por el padre de familia antes de la examinación del médico

Child's Name____ Birthdate_______________________
Nombre del niño/a *Fecha de nacimiento*
Address____ Sex___________________________
Dirección *Sexo*
Parent/Guardian Name____ Phone__________________________
Nombre del padre o apoderado *N.º de teléfono*
Immunizations (fill in the enclosed card with dates (day/month/year) of all immunizations)
Inmunizaciones (complete la tarjeta que acompaña esta forma con las fechas (día/mes/ano) con todas las vacunas)

TO BE COMPLETED BY PHYSICIAN *Esta porción y las que siguen deben ser completadas por los médicos*

- Immunizations given today: DTP______ Polio_______ MMR______ Varicella______ Hep B______
- Is child subject to conditions which may cause classroom emergencies, such as epilepsy, diabetes, fainting, allergies, other? Yes_______ No_______
  If yes, please describe.____
  ____
- Is there any condition which limits student's participation in:
  Classroom activities: Yes_______No_______ Physical Education: Yes_______No_______
  Please explain.____
- Is there any condition for which this child should remain under periodic medical evaluation?
  Yes_____No_____ If yes, please describe.____
- Does child have any other medical problem with which the school should be concerned?
  Yes_____No_____ If yes, please describe.____
- Is there any medication this child requires on an ongoing basis (ie. ADHD, seizures, etc.?)
  Yes_____No_____ Medication authorization form is required. (form available in school office)
- Any hearing, visual, or speech defect for which preferential seating or other action is needed?
  Yes_____No_____ If yes, please describe.____
- I would like the school to contact me regarding this child. Yes_______No_______
- Physician's recommendation and/or comments____
  ____

_________________________ ____
Date of Examination Physician's signature and title

(see reverse side for additional exams)

EYE EVALUATION (requested)

The school board is required to request each student entering kindergarten to provide evidence that the student has had his/her eyes examined by an optometrist or evaluated by a physician.

TO BE COMPLETED BY PHYSICIAN OR OPTOMETRIST *(Check if completed.)*

_____ Brief history of the child (general and eye) including family history

_____ General external observation of the child=s eyes and surrounding structures

_____ Opthalmoscopy examination through an undilated pupil

_____ Gross measurement of peripheral vision

_____ Evaluation of eye coordination and function (alignment and motility)

_____ Visual acuity for each eye (separately)

Physician or Optometrist's recommendations to school regarding the above report: ____________________

____

______________________ ____

Date of Examination Physician/Optometrist's signature

DENTAL EVALUATION (requested)

TO BE COMPLETED BY DENTIST

- Condition of the gingiva (gums) and supporting tissues:
  Satisfactory ____________________________ Infection present __________________________
- Relationship of anterior teeth when biting on posterior teeth
  Closed _____________________________ Open _____________________________
- Evidence of detrimental habits to the oral cavity
  Thumb sucking: Yes _____ No _____ Tongue thrusting: Yes _____ No _____
- Evidence of decay of the teeth
  Yes _____ No _____
- Additional appointment is necessary
  Yes _____ No _____

Dentist's recommendations to school regarding the above report: ___________________________________

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______________________ ____

Date of Examination Dentist's signature

(revised 11/03)