FULTON COUNTY KINDERGARTEN REGISTRATION
PHYSICIAN'S REPORT
** REQUIRED FOR SCHOOL ENTRANCE

Child's Name ______________________ School Attending ______________________

Male ___ Female ___ Age ___ Birth Date ____________

Height ____________ B.P. ____________ Weight ____________ Urine ____________

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 ___

Does this child have asthma? Yes ___ No ___

If yes, does the child have an inhaler? Yes ___ No ___

PHYSICIAN'S ASSESSMENT

Problem List:

1. ______________________________

2. ______________________________

3. ______________________________

Recommendation for school management:

1. ______________________________

2. ______________________________

3. ______________________________

IMMUNIZATIONS RECEIVED TODAY: ____

____

**Please attach an <u>up to date</u> immunization record.

PLEASE PRINT OR STAMP

Physician's Name ______________________ Physician's Signature ______________________

Address ______________________ City ____________ State ___ Zip ________

Phone Number ( ) ______________________ Fax Number ( ) ______________________

Date Signed ____________

This form should be turned in to the school office <u>no later than the second week of classes</u>