Kit Carson School District R-1 Preschool Students Record

Student's Name: Last____________________

Middle____________________

First____________________

Birth date____________________

Address____________________

Date of Enrollment ____________________

Parent/Guardian Information

Name:____________________

Home Address:____________________

Employment Address:____________________

Telephone Number:____________________

Please list the names, address and telephone numbers of persons who are authorized to take the child from preschool.

1.____________________

2.____________________

3.____________________

Name, Address, and Phone Number of the student's physician: ____________________

____

Name, Address, and Phone Number of the student's dentist: ____________________

Please List the Hospital of Choice for your child and Phone Number:

____

Health: Does this student have any health problems that the school should be aware of? If yes, please explain:____________________

____

____

____

Parent/Guardian Signature ____________________ Date:__________

Health Record Form KCSD R-1 Preschool Program

Parents who enroll their child into a preschool program must submit a signed and dated statement of the child's current health status. This should indicate the child's abilities and/or limitations to participate in a regularly scheduled program of play in a group of young children. This report is to be filled out by a licensed physician, licensed nurse practitioner, or the county health nurse. They must have seen the child within the last twelve months.

Child's Name:____ Age:____________________

Birthdate:____ Sex:____________________

Address:____

Past Illnesses: Check those that the child has had and give the date.

Chicken Pox ____

Rheumatic Fever____

Diabetes____

Whooping Cough____

Rubeola____

Asthma____

Mumps____

Polomyelitis____

Rubella____

Hay Fever____

Epilepsy____

Other____

This child is _______ is not _____ physically or emotionally able to participate in the program named above.

Comments:____

____

Surgery/Accidents/Illnesses/Chronic or Handicapping Problems

____

____

Health Record Form KCSD R-1 Preschool Program

Describe any physical condition requiring special attention by the teacher:

____

____

Medication prescribed: ____

Allergies: ____

If tuberculin test given: **Date** ____________ **Result** __________________

If chest x-ray taken: **Date** ____________ **Result** __________________

Vision ____________________ **Hearing** ____________________

Date of my most recent examination of child ________________________

Signature of licensed physician, licensed nurse practitioner or county health nurse

__________________________________ **Date:** ____________________

Please print name, address, and phone number:

____

____

____