



Los Alamos Public Schools

Pre-School and Kindergarten Health Examination by Physician

School child will attend: : Pre-School Kindergarten

Student

Birth Date ____/____/____ Last First MI Gender Male Female School Year _____

Parent/Guardian:

Home Phone # ____ Cell Phone # ____ Work Phone # ____ Last First Relationship

Physician: _____ Fax # _____ Phone # _____

SUMMARY OF PHYSICIANS EXAMINATION

Note to Physician: The information requested below will assist the schools in meeting the child's individual needs.

Table with 3 columns: Vision, Color Vision, Audio

Please check "Yes" or "No" and specify recommendations:

Table with 2 columns: Response (No/Yes) and Question (1-5)

Please attach a copy of the immunization record to this form.

Physician's recommendation to the school: _____

Signature of Physician

Date

Pre-School form: Parents please deliver form to school nurse

Kindergarten form: Los Alamos physicians - Please keep these kindergarten forms until called for by the school nurse

Other physicians - Mail the form to: Los Alamos Public Schools, Attention Student Services, P.O. Drawer 90, Los Alamos, NM 87544

LAPS Date Received _____