

KINDERGARTEN PHYSICIAN'S EXAMINATION FORM

Incoming kindergarten students are required to have a physical exam within 365 days of entering kindergarten. The exam must state what, if any, modifications are required for full participation in the school program. Please return this completed form to the Point Road School office by July 1.

Child's Name _____ Date of Birth _____

Address _____ Phone: _____

History and date of serious illness, injury, surgery, etc. _____

Does child require any of the following (please check all that apply): glasses _____ hearing aid _____
Corrective shoes _____ other _____

Is child presently taking any prescribed medication? If so, please explain: _____

Physical examination: WT _____ HT _____ BP _____ Heart _____ Lungs _____
Eyes _____ Ears _____ Nose _____ Throat _____ Skin _____
Orthopedic _____ Abdomen _____ Speech _____ Lymph nodes _____
General appearance _____

History (give dates where applicable): Asthma _____ Allergies (type) _____
Chicken Pox _____ Drug allergies _____ Hernia _____
Lyme disease _____ Meningitis _____ Mononucleosis _____ Pneumonia _____
Seizure disorder _____ Strep _____ Other _____

The following vaccines are REQUIRED. Please supply **month, day, and year**. (A copy of immunization record may be attached)

DPT: (1) _____ (2) _____ (3) _____ (4) _____ (5) _____
(Minimum 4 doses of DPT required-one must be given after age 4)

OPV or IPV (indicate which): (1) _____ (2) _____ (3) _____ (4) _____
(Any 4 doses or 3 doses if one is given after age 4)

MMR (Measles, Mumps, Rubella): _____
(2 doses after age 1) (1) _____ (2) _____

Hepatitis B: _____
(1) _____ (2) _____ (3) _____

Varicella: (one dose after age 1 or proof of disease immunity) _____

OPTIONAL:

Hepatitis A: (1) _____ (2) _____

Mantoux Tuberculin test: Date: _____ Result: _____

HIB: (1) _____ (2) _____ (3) _____ (4) _____

DATE OF EXAMINATION: _____

SIGNATURE OF PHYSICIAN/CNP: _____

PRINTED NAME OF PHYSICIAN/CNP: _____

LITTLE SILVER SCHOOLS

Little Silver, NJ

Name _____

Health Questionnaire and Developmental History

Does your child have any of the following health conditions now or in the past?

Yes No Explain

Asthma			
Cardiac problems			
Car sickness			
Chronic ear infections			
Chicken pox			
Concussion			
Congenital condition (Specify)			
Diabetes			
Environmental allergies			
Fractured bones			
★ Wears orthopedic device (splint, etc.)			
Frequent headaches			
Head injury			
Hearing problem			
★ Wears hearing aid			
Hives			
Lyme disease			
Migraine headaches			
Seizure disorder			
Sinus infections			
Speech problem/concern			
Strep throat			
Urinary/bowel problems			
Vision problem			
★ Wears glasses or contact lenses (Circle one)			
Other			

1. Does your child have a **life-threatening allergy** (requires an EpiPen) to the following:

	Yes	No	If yes, which one(s)?
Foods			
Insects			
Other			

2. Does your child have any other allergies? Yes No

If yes, please specify type of allergy and reaction (hives, etc.):

3. Does your child take any medications either daily or as needed? Yes No

If yes, please list name of medication, reason for use and how often child takes the medication:

(OVER)

4. Has your child had any serious illness, injury or surgery? Yes No
If yes, please give details and date(s) of illness, injury, hospitalization or surgery:

5. **Birth Data** Full-term _____ Premature _____ (weeks)
Birth weight _____ Apgar score (if known) _____
Please indicate any difficulties during pregnancy or birth: _____

6. **Developmental Data:** Please give approximate ages that your child accomplished the following:

Sat up _____ Walked _____ Talked _____
Toilet trained _____
Left or right handed? _____ Established when? _____

7. Check any of the following patterns that you have observed in your child:
Easily frustrated _____ Completes tasks slowly _____
Exhibits aggressive behavior _____ Shyness _____
Talks a lot _____ Temper tantrums _____ Moody _____
Short attention span _____ Overly active _____
Difficulty communicating needs and wants _____
Other (please specify) _____

8. Has your child ever qualified or been enrolled in a specialized program? Please check all that apply:

Early intervention (please specify) _____
Pre-School _____ Speech _____ Second Language _____
Gifted and Talented _____ Other (please specify) _____

9. Has your child ever had an IEP _____ or 504 Plan _____?

10. Has your child ever received any private therapies? If so, please specify:

11. Do you have any concerns about your child's developmental behavior or emotional well-being that the school should be aware of? _____

12. Do you have any other concerns that you would like to share with us? _____

Student Release Authorization:

In the event that the school is unable to contact the parent/guardian, I authorize that my child may be released to the person(s) listed below:

Name and Relationship to Child Home and Cell Phone Numbers

Name and Relationship to Child Home and Cell Phone Numbers

Parent/Guardian Signature _____ Date _____

Sharing of Information:

I acknowledge that the information noted above may be shared with school staff members on a need-to-know basis for the safety and well-being of my child.

Parent/Guardian Signature _____ Date _____

Point Road School
Student Information Collection Form

Child's Name: _____

1. What type of preschool program did your child attend?

- Full Day Half Day

Where? _____

2. Was it a positive learning experience for your child?

- Yes No

Comments: _____

3. What was your child's remote learning experience, if they had one, like? What types of things did they do? Were their video lessons, Zoom meetings, etc?

4. Please use a checkmark to show if your child has had any of the following experiences.

- Stayed home an extra year before entering school
- Spent an extra year in a day care or nursery school setting
- Took an extra year in a pre-kindergarten program

5. What are your child's strengths? (Social emotional, physical or academic, etc.)

Social: _____

Emotional: _____

Physical: _____

Academic: _____

6. Do you have any concerns about your child's development?

7. Does your child enjoy being read to and/or reading books?

Yes No

Comments: _____

8. What is your child's favorite indoor activity? _____

9. What is your child's favorite outdoor activity? _____

10. Does your child show an interest in drawing?

Yes Not at this time

Comments: _____

11. Can your child hold a crayon or pencil correctly?

Yes Not at this time

Can your child color within the lines of a design?

Yes Not at this time

Comments: _____

12. Can your child hold scissors correctly?

Yes Not easily at this time

If your child is left handed do they use left-handed scissors?)

Yes No

Comments: _____

13. Can your child sit still for a short period of time to?

- | | | |
|--------------------|------------------------------|---|
| Listen to a story? | <input type="checkbox"/> Yes | <input type="checkbox"/> Not at this time |
| Be read to? | <input type="checkbox"/> Yes | <input type="checkbox"/> Not at this time |
| Do a simple task? | <input type="checkbox"/> Yes | <input type="checkbox"/> Not at this time |
| Play a game? | <input type="checkbox"/> Yes | <input type="checkbox"/> Not at this time |

Comments: _____

14. Is your child able to communicate his/her wants, needs and thoughts verbally in his/her primary language?

- Most of the time Some of the time Not at this time

Is there another language spoken at home? If so, what language? _____

- Yes No

Comments: _____

15. Is your child easily learning letter and number names?

- Yes Sometimes Not at this time

Comments: _____

16. Does your child show interest in numbers?

- Yes Sometimes Not at this time

Comments: _____

17. Does your child show interest in sounds and written words?

- Yes Sometimes Not at this time

Comments: _____

18. Can your child dress himself/herself?

- Yes, with a little help Even with help has difficulty

Comments: _____

19. Can your child write his/her first and last name?

Yes

Not at this time

Comments: _____

20. Can your child easily follow?

A single direction or request (“*Please pick up your toys*”)

Yes, most of the time

Some of the time

Not at this time

A two part direction or request (“*Please get your bicycle and put it in the garage*”)

Yes, most of the time

Some of the time

Not at this time

A three part direction or request (“*Please bring me the newspaper, turn on the light and feed the dog*”)

Yes most of the time

Some of the time

Not at this time

Comments: _____

21. What are some of the developmental milestones has your child achieved? (Such as running, catching, throwing, cutting, using a fork, completing puzzles, hopping, skipping, climbing, riding a tricycle or bicycle, etc.)

1. _____

2. _____

3. _____

4. _____

22. Can your child be away from you for an extended time without becoming upset?

- Yes Not at this time Don't know yet

Comments: _____

23. How well does your child react when plans change?

- Becomes upset
 Cries easily
 Accepts change without becoming upset

Any other reactions: _____

24. Is your child able to easily share things such as:

Toys Yes, most of the time Some of the time Not at this time

Pencils/crayons/paper

Yes most of the time Some of the time Not at this time

Comments: _____

Please use this scale when completing the next set of questions.

1 = Never · 2 = Rarely · 3 = Sometimes · 4 = Often · 5 = Almost always

Child is eager to explore new things	1	2	3	4	5
Child asks questions to help s/he learn better	1	2	3	4	5
Child takes an active interest in learning	1	2	3	4	5
Recognizes what other people do for them	1	2	3	4	5
Shows appreciation for opportunities	1	2	3	4	5
Expresses appreciation by saying thank you	1	2	3	4	5
Did something nice for someone else as a way of saying thank you	1	2	3	4	5
Finishes whatever s/he began	1	2	3	4	5
Sticks with a project, activity or toy for more than a few weeks	1	2	3	4	5

Tries very hard even after experiencing failure	1	2	3	4	5
Stays committed to goals	1	2	3	4	5
Keeps working hard even when s/he feels like quitting	1	2	3	4	5
Believes that effort would improve his/her future	1	2	3	4	5
When bad things happened, s/he thinks about things they could do to make it better next time	1	2	3	4	5
Stays motivated, even when things didn't go well	1	2	3	4	5
Believes that s/he could improve on things they weren't good at	1	2	3	4	5
Remains calm even when criticized or otherwise provoked	1	2	3	4	5
Allows others to speak without interrupting	1	2	3	4	5
Is polite to adults and peers	1	2	3	4	5
Keeps temper in check	1	2	3	4	5
Goes to class prepared	1	2	3	4	5
Remembers and follows directions	1	2	3	4	5
Starts working right away	1	2	3	4	5
Pays attention and resists distractions	1	2	3	4	5
Is able to find solutions during conflicts with others	1	2	3	4	5
Shows that s/he cares about the feelings of others	1	2	3	4	5
Adapts to different social situations	1	2	3	4	5
Actively participates	1	2	3	4	5
Shows enthusiasm	1	2	3	4	5
Approaches new situations with excitement and energy	1	2	3	4	5

25. What other information would you like us to be aware of that will help us get to know your child? (i.e., personality traits, likes/dislikes, early development, family history of learning difficulties)
