



Bethlehem Central Schools  
Kindergarten Registration

FORM E/Blue

### PHYSICAL APPRAISAL REPORT (Required **BEFORE** student enters K)

Home School *(Please circle one)*    CLK    EAG    ELS    GLE    HAM    SLI

Student Name \_\_\_\_\_ Grade \_\_\_\_\_ M or F *(please circle)*

Address \_\_\_\_\_ Town \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone \_\_\_\_\_

Date of Birth \_\_\_\_\_

Teacher \_\_\_\_\_

**Parent or guardian: Please bring this form to school after completion by your child's physician .**

#### HEALTH HISTORY

_____ Allergies	_____ Eye Conditions	_____ Scarlet Fever
_____ Bee sting	_____ Hearing Problem	_____ Seizures
_____ Food	_____ Heart Disease	_____ With fever
_____ Other	_____ Hyperkinesis	_____ Without fever
_____ Anemia	_____ Kidney Disease	_____ Speech Problem
_____ Asthma	_____ Learning Disabilities	_____ Strep Throat
_____ Cerebral Palsy	_____ Leukemia	_____ TB
_____ Chicken Pox	_____ Measles Disease	_____ Chest X-ray
_____ Colds & Sore Throats	_____ Mononucleosis	_____ TB Contact
_____ Cystic Fibrosis	_____ Mumps Disease	_____ TB test results
_____ Diabetes	_____ Orthopedic Conditions	_____ Urinary Infections
_____ Ear Infections	_____ Pneumonia	_____ Vision Problem
_____ PE Tubes	_____ Rheumatic Disease	_____ Whooping Cough
	_____ Rubella Disease	

Problems at birth \_\_\_\_\_

Serious injuries \_\_\_\_\_

Surgeries \_\_\_\_\_

Other concerns \_\_\_\_\_

Please list all over the counter and prescription medications, including dose and frequency: \_\_\_\_\_

**Are there any physical restrictions or limitations for physical education class or other activities in school?**

Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, list \_\_\_\_\_

#### PHYSICAL

Immunizations during past year (List type, month, day, year) \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Body Mass Index \_\_\_\_\_ . \_\_\_\_\_

Weight Status Category:

Less than 5th     5<sup>th</sup> through 49<sup>th</sup>     50<sup>th</sup> through 84<sup>th</sup>     85<sup>th</sup> through 94<sup>th</sup>     94<sup>th</sup> through 99<sup>th</sup>     99<sup>th</sup> and higher

Blood Pressure \_\_\_\_\_ Normal Pulse \_\_\_\_\_

Eyes (R) \_\_\_\_\_ (L) \_\_\_\_\_ Ears (R) \_\_\_\_\_ (L) \_\_\_\_\_ Tonsils \_\_\_\_\_

Teeth \_\_\_\_\_ Cervical \_\_\_\_\_ Thyroid \_\_\_\_\_ Other \_\_\_\_\_ Heart \_\_\_\_\_

Lungs \_\_\_\_\_ Abdomen \_\_\_\_\_ Hernia \_\_\_\_\_ Nervous System \_\_\_\_\_ Posture \_\_\_\_\_

Orthopedic \_\_\_\_\_ Scoliosis (see reverse if positive) \_\_\_\_\_ Feet \_\_\_\_\_ Skin \_\_\_\_\_

Genitourinary \_\_\_\_\_ Urine testing: Sugar \_\_\_\_\_ Protein \_\_\_\_\_

**General Condition** \_\_\_\_\_

**Recommendations** \_\_\_\_\_

**Physician's Signature** \_\_\_\_\_ **Date of exam** \_\_\_\_\_

**Physician's Name or Stamp** \_\_\_\_\_

Student's name \_\_\_\_\_ Grade \_\_\_\_\_ Date of exam \_\_\_\_\_

Additional health history information: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SCOLIOSIS SCREENING**

*Effective September 1982, New York State Law requires annual scoliosis screening for each child between the ages of 8 and 16.*

**Please check any positive findings:**

- |                              |       |       |
|------------------------------|-------|-------|
| 1. Forward bend              |       |       |
| Thoracic prominence          | L ( ) | R ( ) |
| Lumbar prominence            | L ( ) | R ( ) |
| 2. Shoulder higher           | L ( ) | R ( ) |
| 3. Prominent scapula         | L ( ) | R ( ) |
| 4. Elevated scapula          | L ( ) | R ( ) |
| 5. Iliac crest higher        | L ( ) | R ( ) |
| 6. Arm to body space greater | L ( ) | R ( ) |
| 7. Recommendations:          |       |       |

Screened by: \_\_\_\_\_

Physician's name or stamp: \_\_\_\_\_