



# Uncle Sam's Academy Additional Health Information Form

Enrollment Date: \_\_\_\_\_ Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Parent's Name \_\_\_\_\_ Resident School District Name/Number: \_\_\_\_\_

## VISION

Directions: To be completed by doctor

**Year 1** Date \_\_\_\_\_ Doctor's initials \_\_\_\_

(check if performed)

Pupillary Response \_\_\_\_\_

Corneal Light Reflex \_\_\_\_\_

Alternate Cover \_\_\_\_\_

Tracking \_\_\_\_\_

Steropsis \_\_\_\_\_

**Year 2** Date \_\_\_\_\_ Doctor's initials \_\_\_\_

(check if performed)

Pupillary Response \_\_\_\_\_

Corneal Light Reflex \_\_\_\_\_

Alternate Cover \_\_\_\_\_

Tracking \_\_\_\_\_

Steropsis \_\_\_\_\_

**Year 3** Date \_\_\_\_\_ Doctor's initials \_\_\_\_

(check if performed)

Pupillary Response \_\_\_\_\_

Corneal Light Reflex \_\_\_\_\_

Alternate Cover \_\_\_\_\_

Tracking \_\_\_\_\_

Steropsis \_\_\_\_\_

Acuity Screening (annually over 2 years of age)

right \_\_\_\_\_ left \_\_\_\_\_

Acuity Screening (annually over 2 years of age)

right \_\_\_\_\_ left \_\_\_\_\_

**DENTAL** Date of last dental visit. Attach documentation of visit.

DATE: Year 1 \_\_\_\_\_ Year 2 \_\_\_\_\_ Year 3 \_\_\_\_\_

Directions: Circle Y or N

Does anything appear abnormal (swelling, redness, apparent decay) on the child's teeth or gums? Y N

Is brushing teeth/gums a part of your child's daily routine? Y N

Does your child fall asleep with a bottle/sipper cup in his/her mouth? Y N

**HEARING** Date of last audiology evaluation. (Date completed) Attach readout or record results

Year 1 \_\_\_\_\_ Year 2 \_\_\_\_\_ Year 3 \_\_\_\_\_

Directions: Circle Y or N

Has your child had ear infections? Y N If yes, how many? \_\_\_\_\_ Date of last infection. \_\_\_\_\_



# Corporate Kids, 601 Additional Health Information Form

Enrollment Date: \_\_\_\_\_ Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Parent's Name \_\_\_\_\_ Resident School District Name/Number: \_\_\_\_\_

## VISION

Directions: To be completed by doctor

**Year 1** Date \_\_\_\_\_ Doctor's initials \_\_\_\_\_

(check if performed)

Pupillary Response \_\_\_\_\_

Corneal Light Reflex \_\_\_\_\_

Alternate Cover \_\_\_\_\_

Tracking \_\_\_\_\_

Steropsis \_\_\_\_\_

**Year 2** Date \_\_\_\_\_ Doctor's initials \_\_\_\_\_

(check if performed)

Pupillary Response \_\_\_\_\_

Corneal Light Reflex \_\_\_\_\_

Alternate Cover \_\_\_\_\_

Tracking \_\_\_\_\_

Steropsis \_\_\_\_\_

**Year 3** Date \_\_\_\_\_ Doctor's initials \_\_\_\_\_

(check if performed)

Pupillary Response \_\_\_\_\_

Corneal Light Reflex \_\_\_\_\_

Alternate Cover \_\_\_\_\_

Tracking \_\_\_\_\_

Steropsis \_\_\_\_\_

Acuity Screening (annually over 2 years of age)

right \_\_\_\_\_ left \_\_\_\_\_

Acuity Screening (annually over 2 years of age)

right \_\_\_\_\_ left \_\_\_\_\_

**DENTAL** Date of last dental visit. Attach documentation of visit.

Year 1 \_\_\_\_\_ Year 2 \_\_\_\_\_ Year 3 \_\_\_\_\_

Directions: Circle Y or N

Does anything appear abnormal (swelling, redness, apparent decay) on the child's teeth or gums? Y N

Is brushing teeth/gums a part of your child's daily routine? Y N

Does your child fall asleep with a bottle/sipper cup in his/her mouth? Y N

**HEARING** Date of last audiology evaluation. Attach readout or record results

Year 1 \_\_\_\_\_ Year 2 \_\_\_\_\_ Year 3 \_\_\_\_\_

Directions: Circle Y or N

Has your child had ear infections? Y N If yes, how many? \_\_\_\_\_ Date of last infection. \_\_\_\_\_