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 I 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 _____

Acuity Screening (annually over 2 years of age)

right _____ left _____

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 _____

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

DATE: Year I _____ 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 I _____ 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 I 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 _____

Acuity Screening (annually over 2 years of age)

right _____ left _____

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 _____

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

Year I _____ 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 I _____ 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. _____