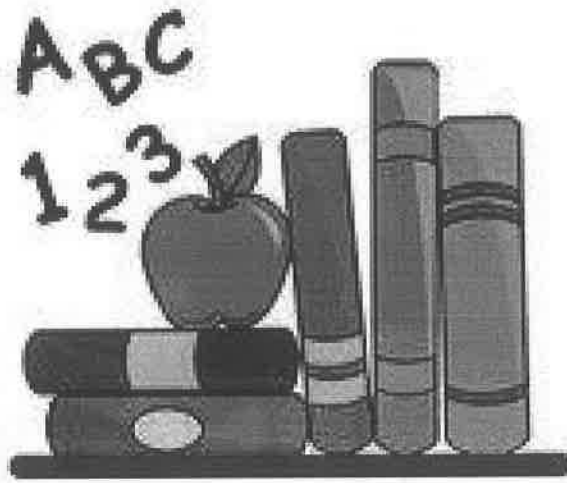


LET'S GET READY FOR KINDERGARTEN



Activity Packet
Evangel Christian School
Summer 2018



GRADE: KINDERGARTEN

Supplies and Material Needed for September

The following supplies will be needed for the start of the school year. This list was prepared to enable you to plan ahead and take advantage of summer sales.

1. One (1) hard covered composition notebooks (stitched down the center, not glued, labeled with child's name).
2. Large school bag or backpack with name (without wheels)
3. Lunch bag or box
4. Two (2) large boxes of tissues for classroom use
5. Two (2) folders with pockets (plastic folders, they last longer)
6. A small sheet to rest their heads on.
7. Two (2) boxes of crayola crayons (24 in a box small ones, not fat ones). Label each crayon with name.
8. One (1) pair of scissors (blunt metal bladed - Fishers are the best)
9. One (1) packs of 4 glue sticks & One (1) Elmer's glue
10. Large zippered pencil case
11. One (1) pack of #2 pencils
12. One (1) box of galloon zip lock sandwich bags
13. One (1) small box of sandwich bags
14. A change of clothing to stay at school
15. Two (2) Clorox or Lysol wipes
16. Two (2) Baby wipes
17. One (1) hand sanitizer



PLEASE BRING ALL OF THE ABOVE ITEMS TO SCHOOL ON THE FIRST DAY

***ALL SUPPLIES AND MATERIALS SHOULD BE LABELED WITH CHILD'S NAME AND CLASS. PLEASE HAVE NAMES IN ALL SWEATERS, JACKETS, HATS, BOOTS, GLOVES, ETC. THIS IS VERY IMPORTANT FOR ESTABLISHING GOOD PERSONAL HABITS OF CARING FOR ONE'S PROPERTY. PERIODICALLY, THROUGHOUT THE YEAR, YOUR CHILD MAY NEED TO UPDATE HIS/HER SUPPLIES. THE TEACHER LET YOU KNOW.**



***** PARENTS: PLEASE NOTE *****

Evangel Christian School is committed to Christian principles and values. This task is made more difficult by the media. Most of the TV, advertising, videos, movies and music have a negative impact on our children. To maintain a positive standard, we must ask that all parents cooperate with us by NOT SENDING TO SCHOOL -- supplies (such as book bags, lunch boxes, knapsacks, folders, pencils, erasers. etc.) which have pictures or designs depicting violent characters, scenes or symbols of movie, video or cartoon characters that emphasize anti-social behavior and non-Christian principles; for example, **Power Rangers, X-Men, Batman, Goosebumps, Harry Potter, WWF, Zodiac symbols, Pokémon and similar characters, and secular entertainers.**



Summer Reading Tips for Parents



- Read to your child. Try to establish a daily routine that includes a time to read together. Bedtime is a traditional favorite, but any time will work that is convenient for you and your family.
- Be a good role model. Let your child see you reading for pleasure as well as for information. Let her/him know that you value reading.
- Give your child the opportunity to read aloud to you, a friend, another family member or another child. Make the experience a chance for your child to share his new reading skills. Have him/her read the book silently before asking him/her to read it aloud. Correct mistakes only when the mistake changes the meaning of the sentence and then supply the word without making him feel bad for having made a mistake.
- Include your child in your day-to-day reading experiences. Share recipes, the newspaper, magazines, the TV Guide, cereal boxes, menus, road signs, etc. Our world is full of things to read if we are aware of our surroundings.
- Talk to your child about the books she is reading. Tell her about books you enjoyed when you were a child and ones that you are reading now.
- Help him/her to select books on topics he/she is interested in and on his/her reading level. A simple rule of thumb for helping your child select books at his/her reading level is to have them choose a page in the book (not the first one) and read it. If he doesn't know five or more of the words, then the book is too hard for pleasure reading.
- If you are planning a vacation this summer, write to the visitors' bureau of places you will be visiting and ask for information on the area and any special attractions, check out books from the library to get background information, or get brochures from your travel agent, share this information with your child; ask for his/her input on what activities he/she would enjoy. Hang a map of the places you will be visiting and/or traveling through on the wall and chart your travel route. These techniques will work after travel too.
- Carry a bag with books and activities to keep your child occupied whenever you have to wait.
- Get your child his/her own library card. Take or allow him/her to go to the library often browse for books and enjoy special activities.
- Help him/her new words. Make a goal of one new word a day. Discuss words they come across and don't know. This will help him/her to explain their vocabulary.

Recommended Reading for Fountas and Pinnell Guided Reading
Compiled by RCS Media Specialists

KINDERGARTEN

LEVEL A

<u>Title</u>	<u>AUTHOR</u>
At the Beach	Dana Meachen Rau
Big Egg *	Molly Coxe
Big or Small?	Susan Ring
Eating Apples	Gail Saunders-Smith
Look What I Can Do	Jose Aruego
Margret & H.A. Rey's Curious George	
Feed the Animals	Houghton Mifflin
Puppy Mudge Finds a Friend	Cynthia Rylant
Surprise!	Mercer Mayer
Snow	Cassie Mayer
Taking Care of Pets	Susan Ring

* Highly Recommended

LEVEL B

<u>Title</u>	<u>AUTHOR</u>
Astronaut	Karen Hoenecke
At the Zoo	Dana Meachen Rau
Dogs and Puppies	Ann Marie Kishel
G is for Grass	Marcia Freeman
Horse	JoAnn Macken
Raindrops	Larry Dane Brimner
Truck *	Donald Crews
What is in Space?	Vita Jimenez
What Shape is it?	Sheila Rivera
Yellow	Melanie Mitchell

* Highly Recommended

LEVEL C

<u>Title</u>	<u>AUTHOR</u>
Animals in Winter	Jane Snyder
Boats, Boats, Boats	Susan Ring
Bugs!	Pat McKissack
Family Pets (and others of the Families series)	Lola Schaefer
Firefighters	Alison Behnke
The Fox	Janice Boland
Homes (and others of the Basic Human Needs series)	Robin Nelson
Is it Alive? (and others of the Learn to Read, Read, to Learn Science series)	Kimberlee Graves
Over and Under (and others of the Location series)	Sheila Rivera
Police Officers	Shannon Knudsen
School Bus *	Donald Crews

* Highly Recommended

**Recommended Reading for Fountas and Pinnell Guided Reading
Compiled by RCS Media Specialists**

KINDERGARTEN

LEVEL D

Title	AUTHOR
Apple Trees (and others of the Plants-Life Cycles series)	Gail Saunders-Smith
Ballerina Girl	Kirsten Hall
Bears, Bears Everywhere	Rita Milios
Big Pig, Little Pig	David McPhail
Buttercurp the Clumsy Cow	Julia Moffatt
Car Wash Kid	Cathy Goldbert Fishman
Cat Traps	Molly Coxe
City Mouse and Country Mouse	Rozanne Lanczak Williams
From Bud to Blossom	Gail Saunders-Smith
Goodnight Little Kitten	Nancy Christensen
Leo's Tree	Debora Pearson
Let's Be Friends	Michael K. Smith
The Little Red Hen *	Lucinda McQueen
Monsters!	Diane Namm
Old MacDonald Had a Farm	Carol Jones
Rick is Sick	David McPhail
Shoes *	Elizabeth Winthrop
Sleep-Over Mouse	Mary Packard
Sleepy Dog *	Harriet Ziefert
Spiders, Spiders Everywhere! (and others of the Learn to Read, Read to Learn Math Series)	Rozanne Lanczak Williams
The Tooth Fairy *	Kirsten Hall

* Highly Recommended

I can write my name!



Practice

Handwriting practice lines consisting of multiple rows of solid top and bottom lines with a dashed middle line.

Name: _____

Writing Your Address

Write your address on the lines below.

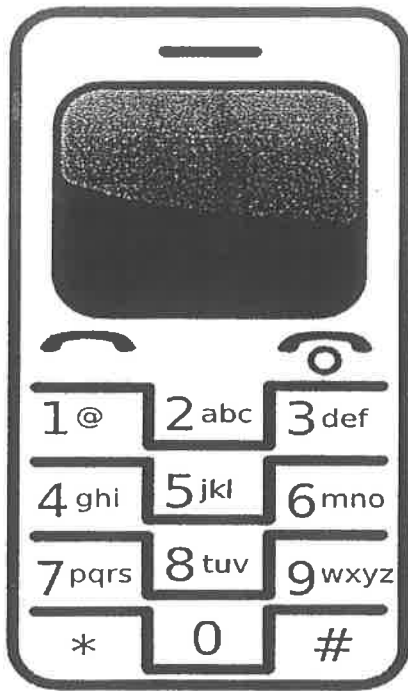
Four sets of handwriting lines, each consisting of a solid top line, a dashed middle line, and a solid bottom line.

Draw a picture of where you live.

A large empty rectangular box for drawing.



I know my phone number!



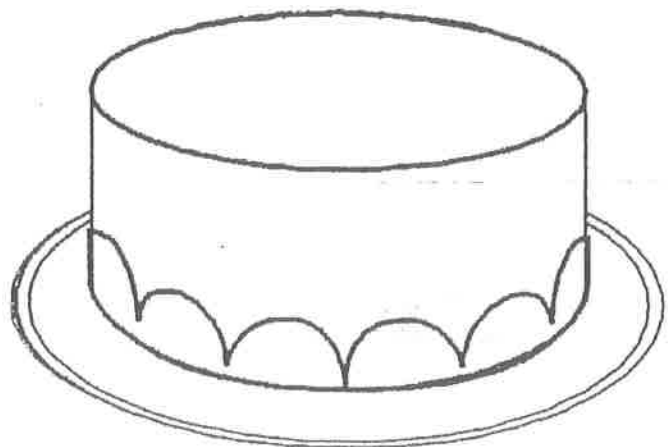
Practice
dialing your
phone
number

Practice writing
your phone number

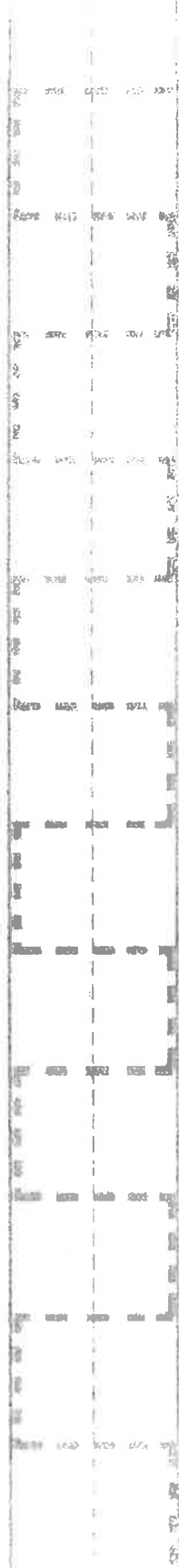
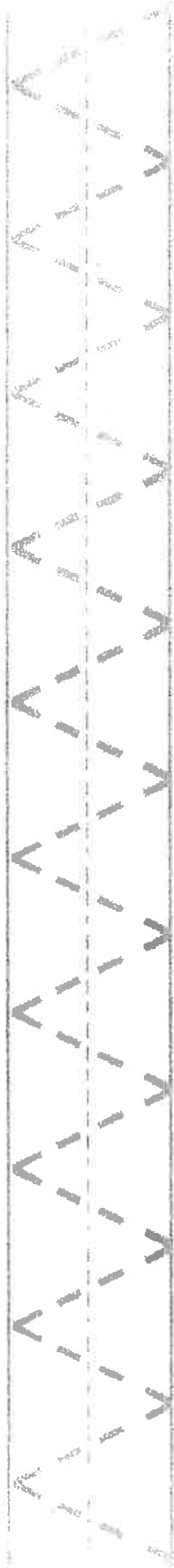
My Birthday is on:

I am _____ years old.

How old will you be on
your next birthday?
Draw the correct
number of candles on
the cake.



Name: _____



Example Uppercase Letters

A B C D E

F G H I J

K L M N O

P Q R S T

U V W X Y

Z

Example Lowercase Letters

a b c d e

f g h i j

k l m n o

p q r s t

u v w x y

z

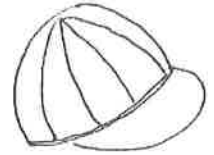
Aa



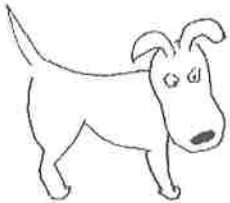
Bb



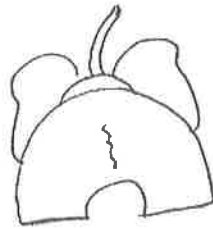
Cc



Dd



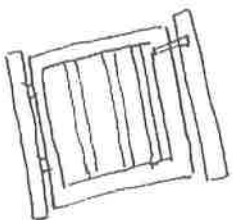
Ee



Ff



Gg



Hh



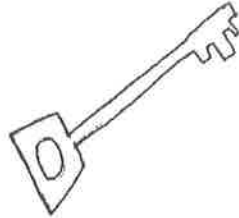
Ii



Jj



Kk



Ll



Mm



Nn



Oo



Pp



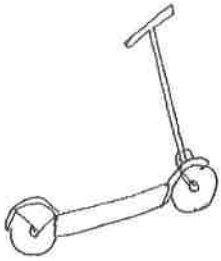
Qq



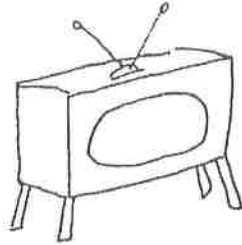
Rr



Ss



Tt



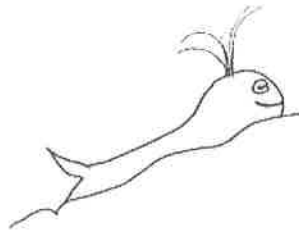
Uu



Vv



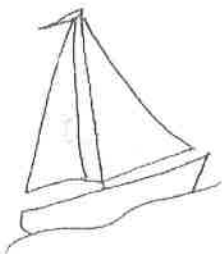
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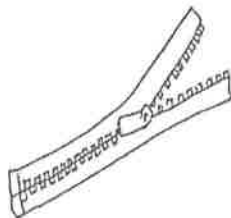
Xx



Yy



Zz



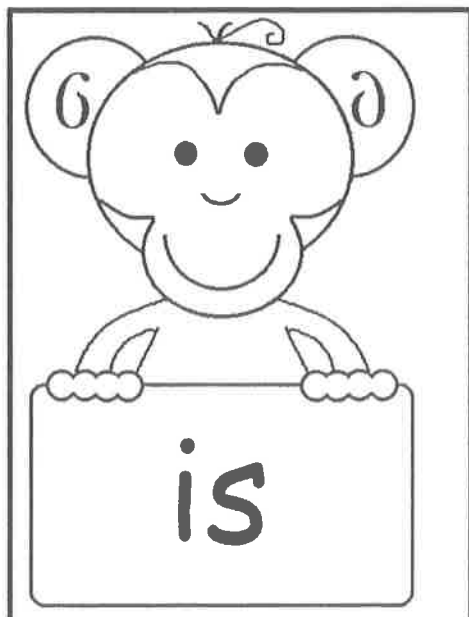
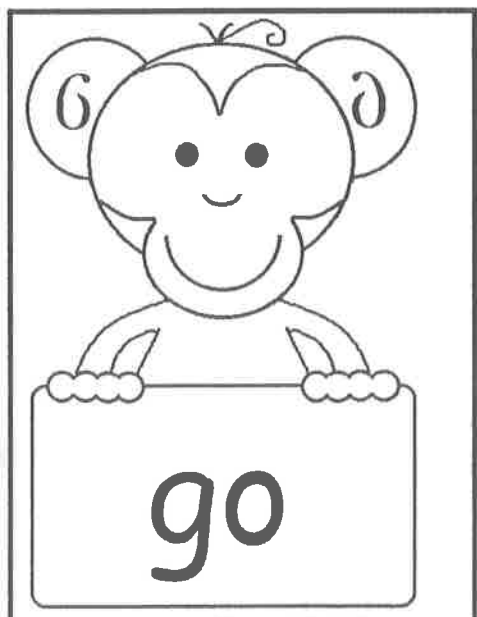
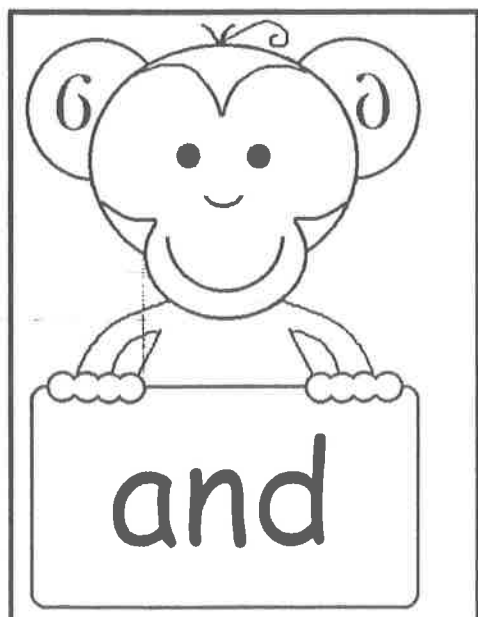
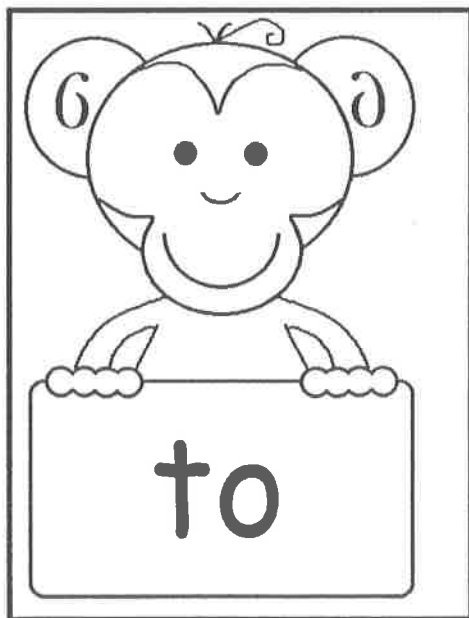
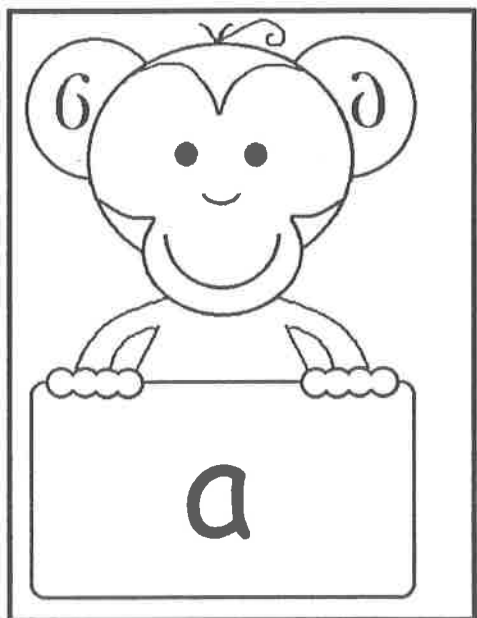
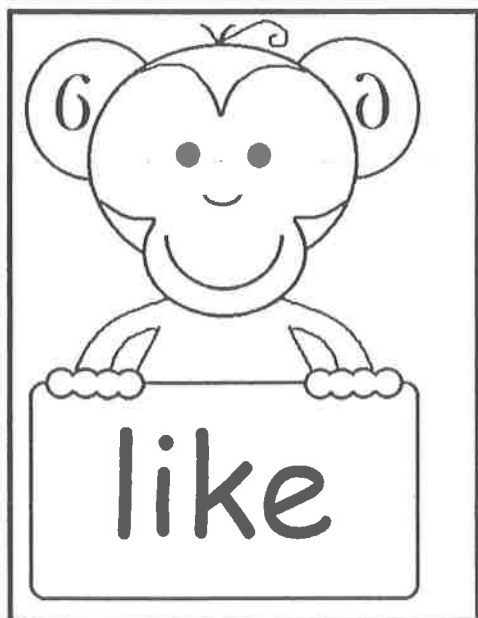
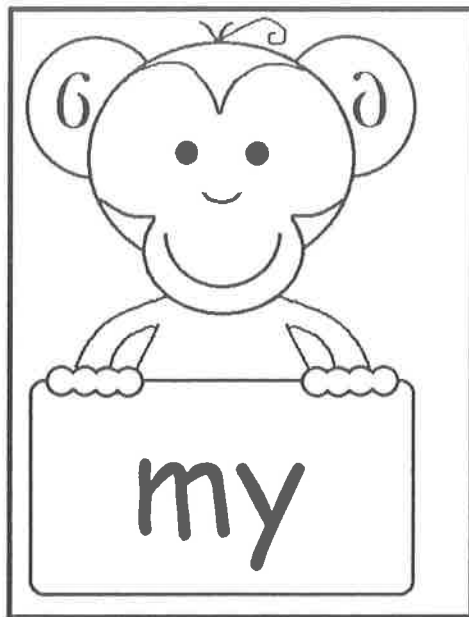
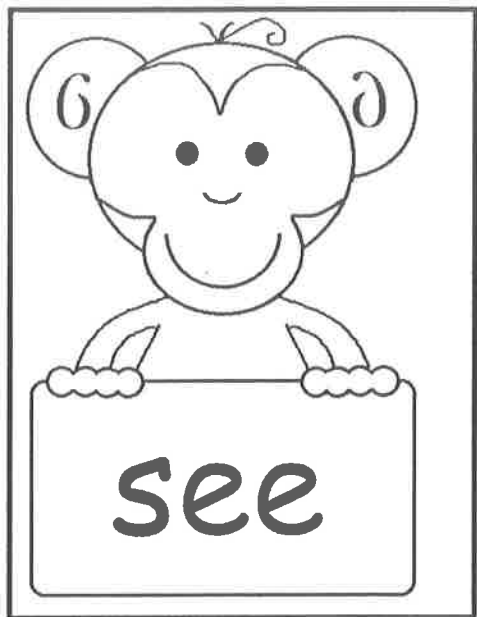
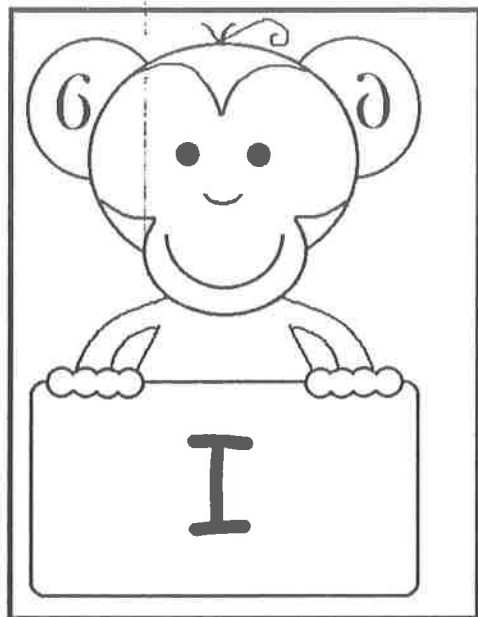
Alphabet Cards

Color the pictures & practice the sound for each letter. Can you put the letters in the correct order?

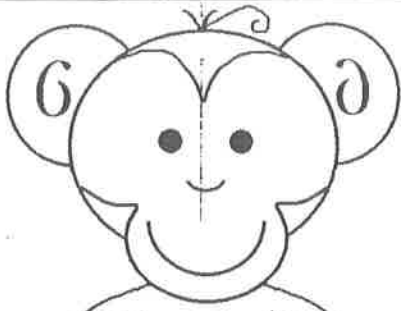
Pre- Primer Sight Words

a	I	run
and	in	said
away	is	see
big	it	the
blue	jump	three
can	little	to
come	look	two
down	make	up
find	me	we
for	my	where
funny	not	yellow
go	one	you
help	play	
here	red	

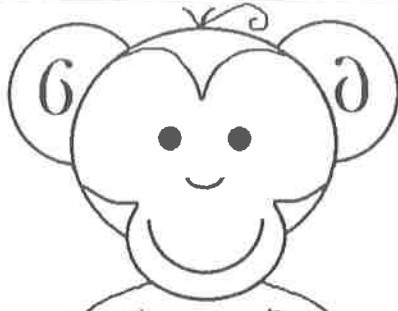
Words to Know for Kindergarten



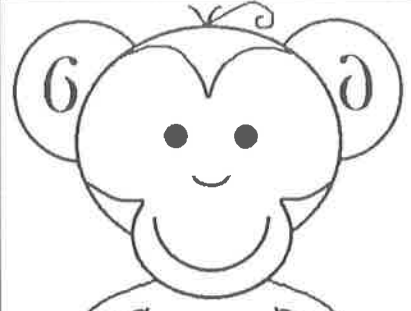
Words to Know for Kindergarten



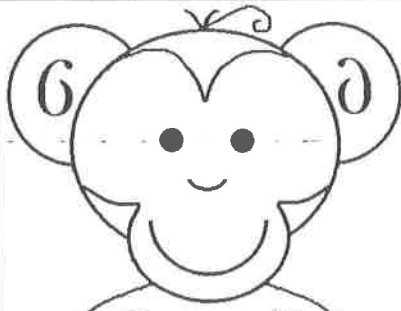
here



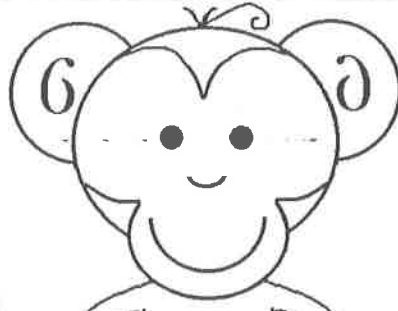
for



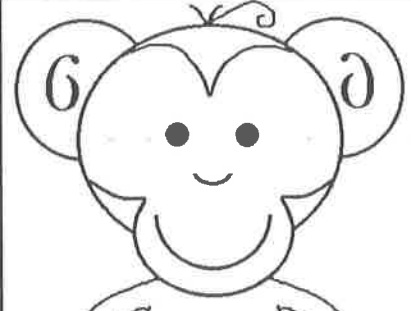
have



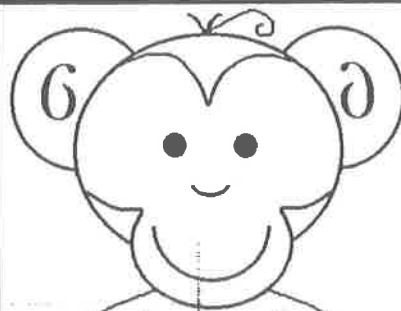
said



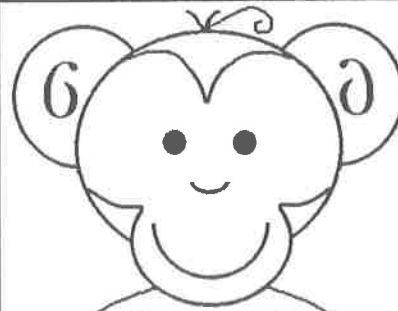
the



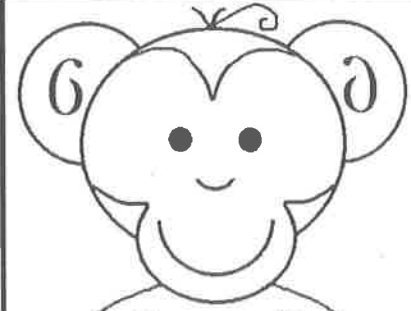
play



she

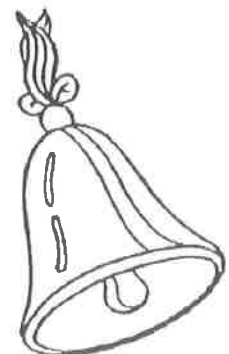
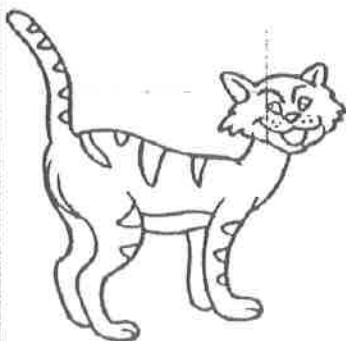
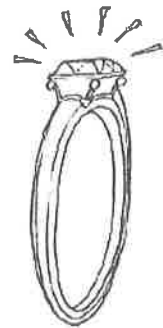
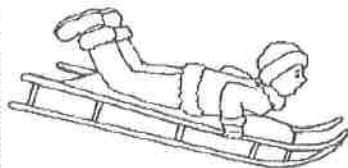
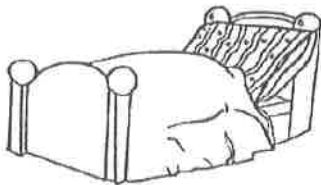
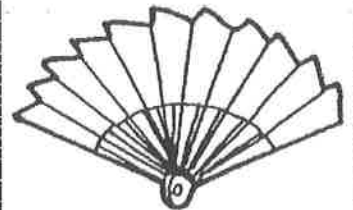
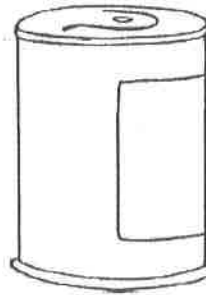
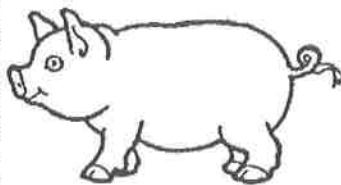
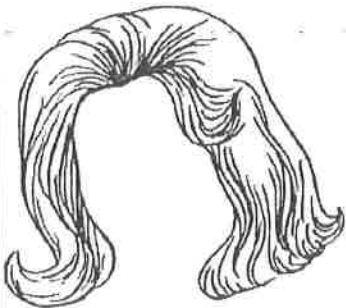
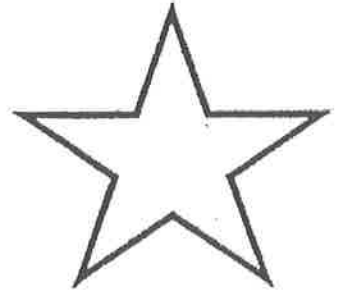
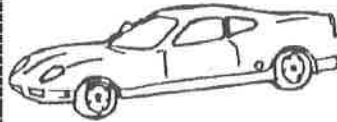
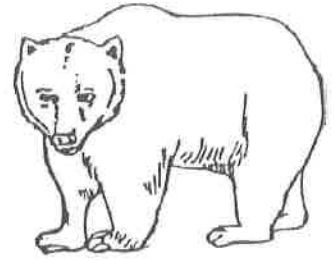
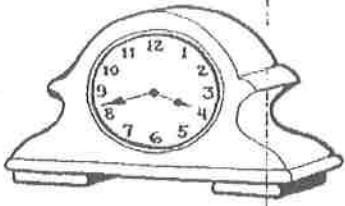


are

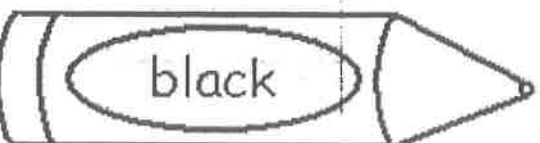
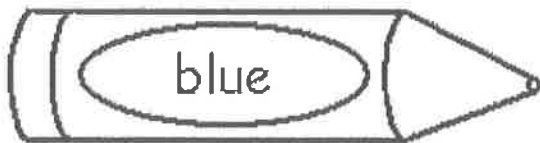
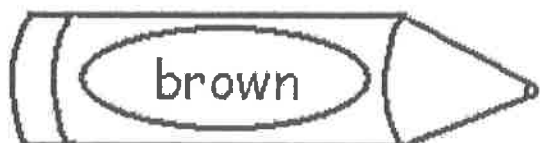
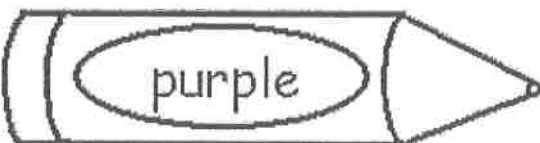
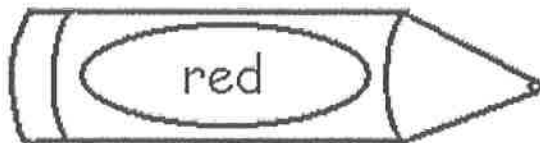


he

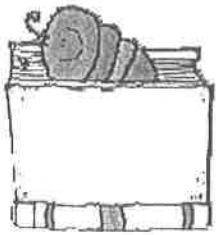
Color, cut out the cards, and play a rhyming match game!



Name: _____



Color the crayons to match their labels.



Summer Book Bingo

After reading these books to your child, have your child color the square or place a sticker over the square. Keep going until you fill the chart!

READ BOOKS BY MO WILLEMS.	Relax & read a book outside.	check out a book from the public library.	Read a fairy tale.	Read a children's magazine.
Read a non- fiction book.	Read a book by Jan Brett and pick an activity from janbrett.com.	Read or recite nursery rhymes.	Tell a family member all about a book you like. Who are the characters? What do they do? What do they say?	Go to storylineonline.net to have a book read to you.
Read books by Laura Numeroff.	Read a poem from a poetry book for children.	Make your own book and read it to a family member or friend.	READ A BOOK ABOUT ANIMALS.	Read books by Eric Carle.
READ A BOOK ABOUT THE BEACH OR OCEAN	READ A BOOK TO LEARN ABOUT A TOPIC THAT INTERESTS YOU.	Listen to an audio book.	Draw or paint a picture about a book you have read.	Read a counting book.



Summer Reading Log



Complete and turn in the log with your summer packet.
Use a highlighter and highlight the books your child
read independently.

Name: _____

Title

Author

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

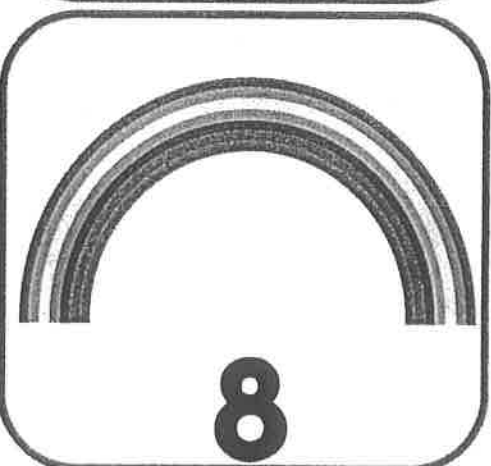
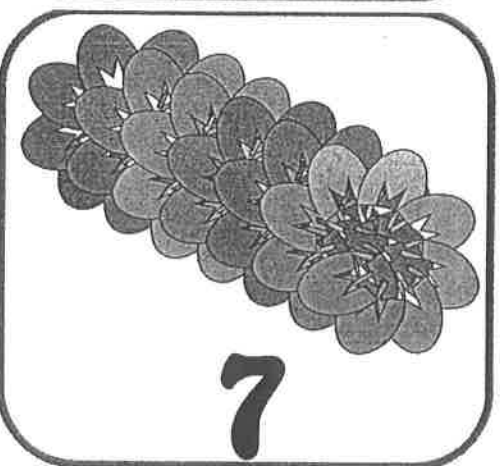
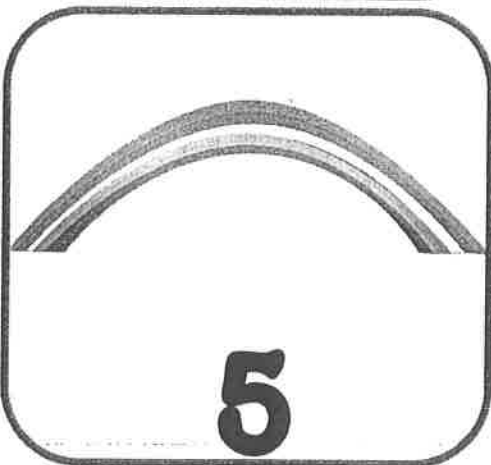
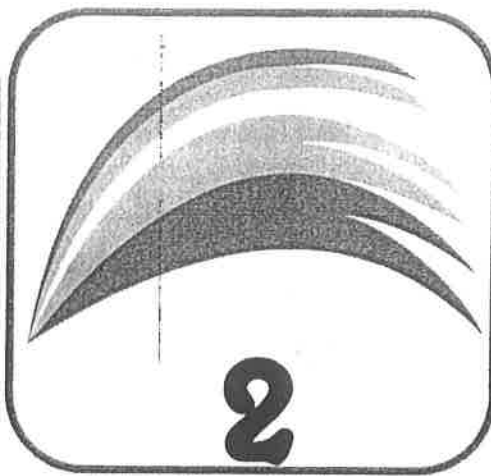
7. _____

8. _____

9. _____

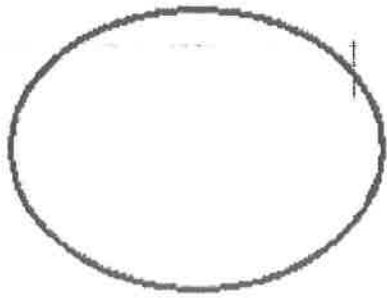
10. _____

My favorite book was:

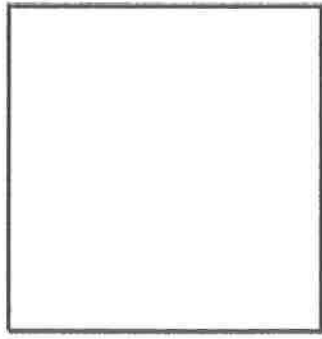


Cut out the numbers and name them. Practice putting them in order.

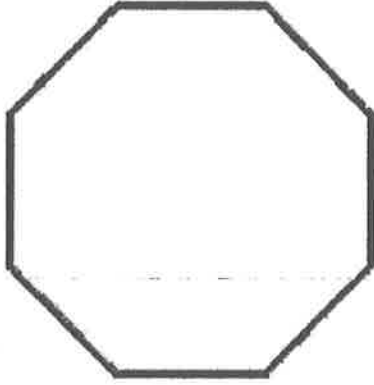
I know these shapes.



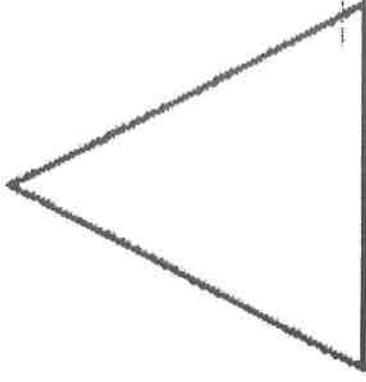
oval



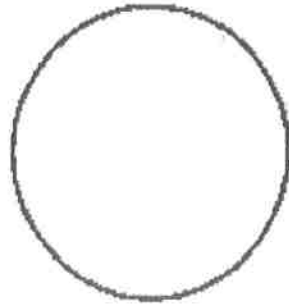
square



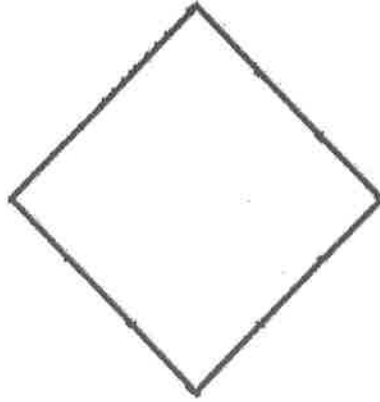
octagon



triangle



circle



rhombus

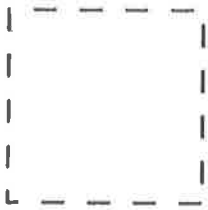


rectangle

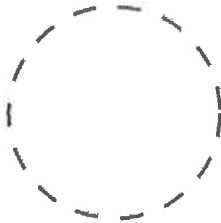


trapezoid

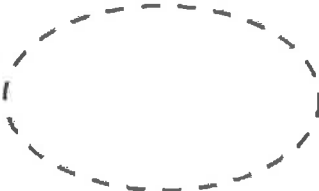
Example Shapes and Names



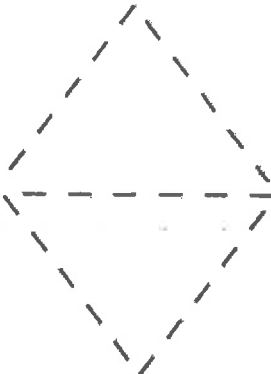
Square



Circle



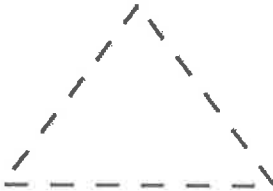
Oval



Diamond



Rectangle



Triangle

Math Activity 3: Sorting

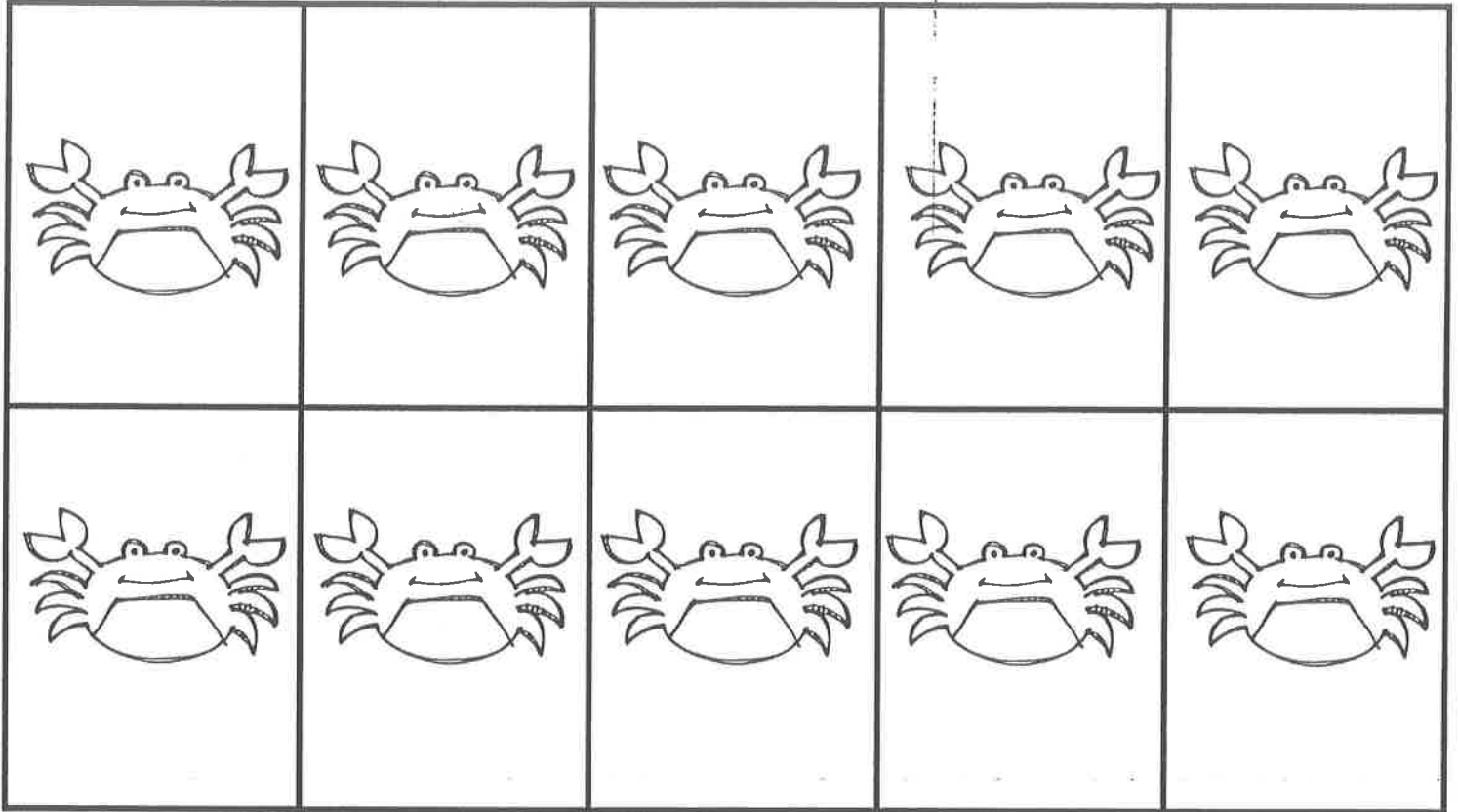
Can Sort

Sort cans in your house by size. Start at the bottom and color the squares on the graph to show how many cans of each size you found.

6			
5			
4			
3			
2			
1			
	small	medium	large



Crabs on the Beach



Ten-Frame Grid Game

You Need:

Dice

Beans, cereal, pennies, or other objects for counters

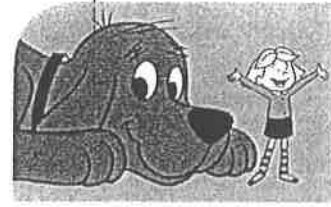
Directions: Color the crabs. Roll the die & put that number of objects on the grid. Clear the grid & roll a new number.

•Ask your child to describe their number to you. (*My number is 6. It's 1 more than 5. It's 4 away from 10.*)

Websites for Fun & Learning!



<http://www.starfall.com/>



<http://www.scholastic.com/clifford/>



<http://www.seussville.com/>



http://www.fisher-price.com/en_US/GamesAndActivities/onlinegames/index.html



<http://www.funbrain.com/>



<http://pbskids.org/games/index.html>



<http://pbskids.org/sesame/>



<http://www.meddybemps.com/>



<http://funschool.kaboose.com/preschool/games/index.html>
















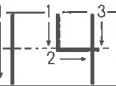
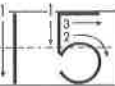


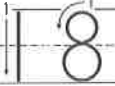
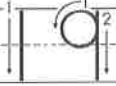
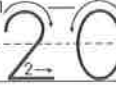
<http://www.kindersite.org/Directory/DirectoryFrame.htm>






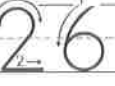

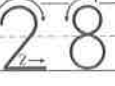


Name: _____ Date: _____

Number Writing Practice 1-30

Trace the numbers 1-30 and then write 1-30 (2 times) in the blank boxes!

									
1	2	3	4	5	6	7	8	9	10

									
11	12	13	14	15	16	17	18	19	20

									
21	22	23	24	25	26	27	28	29	30

Order of Letters - Uppercase

Kindergarten Alphabet Worksheet

Fill in the missing letters in each line!

A	_____	C	_____	_____	F
---	-------	---	-------	-------	---

_____	E	F	_____	_____	_____
-------	---	---	-------	-------	-------

R	_____	_____	_____	_____	W
---	-------	-------	-------	-------	---

_____	_____	_____	X	Y	Z
-------	-------	-------	---	---	---

_____	Q	_____	_____	T	_____
-------	---	-------	-------	---	-------

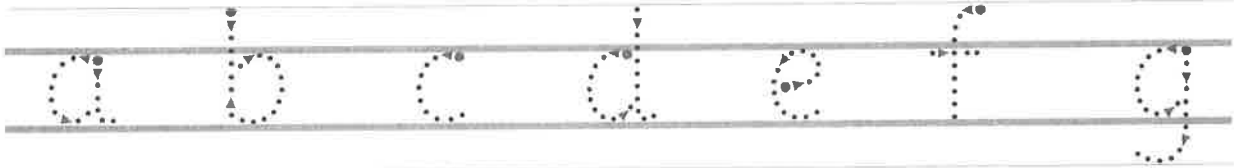
_____	H	_____	J	_____	_____
-------	---	-------	---	-------	-------

The alphabet

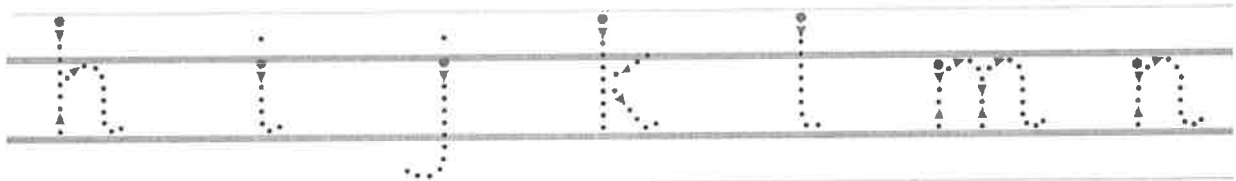


Now you can write all your letters.
Copy each letter by connecting the dots.

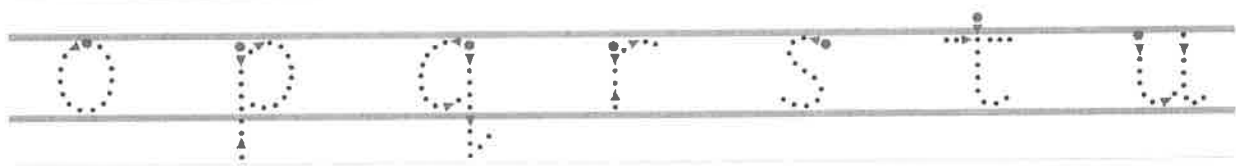
a b c d e f g



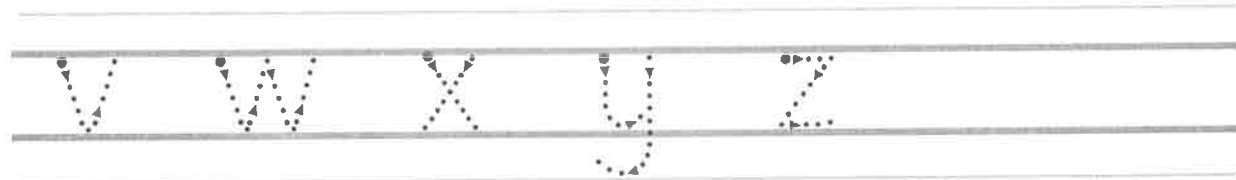
h i j k l m n



o p q r s t u

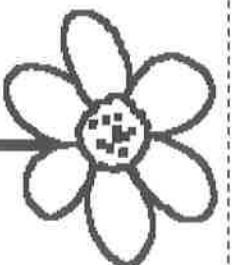
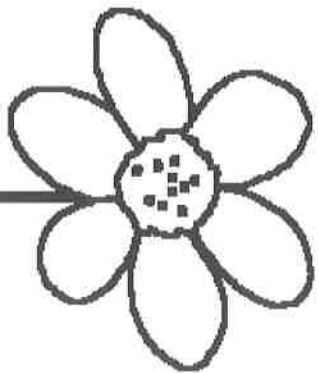
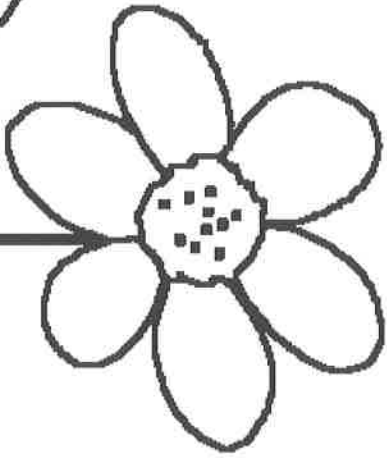
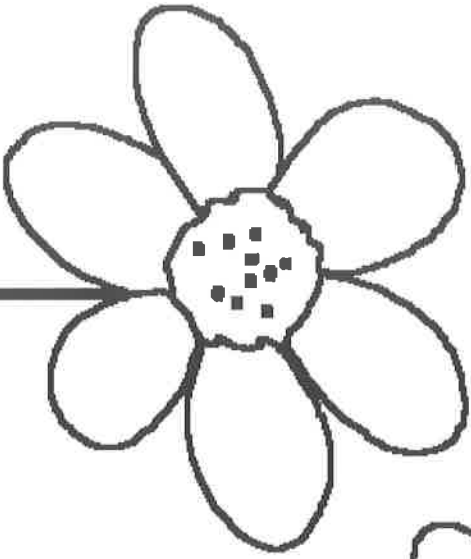
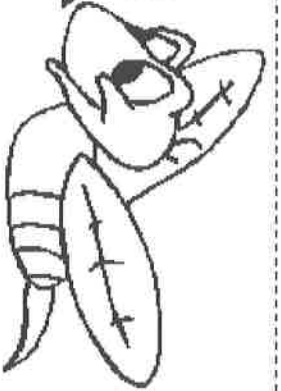


v w x y z



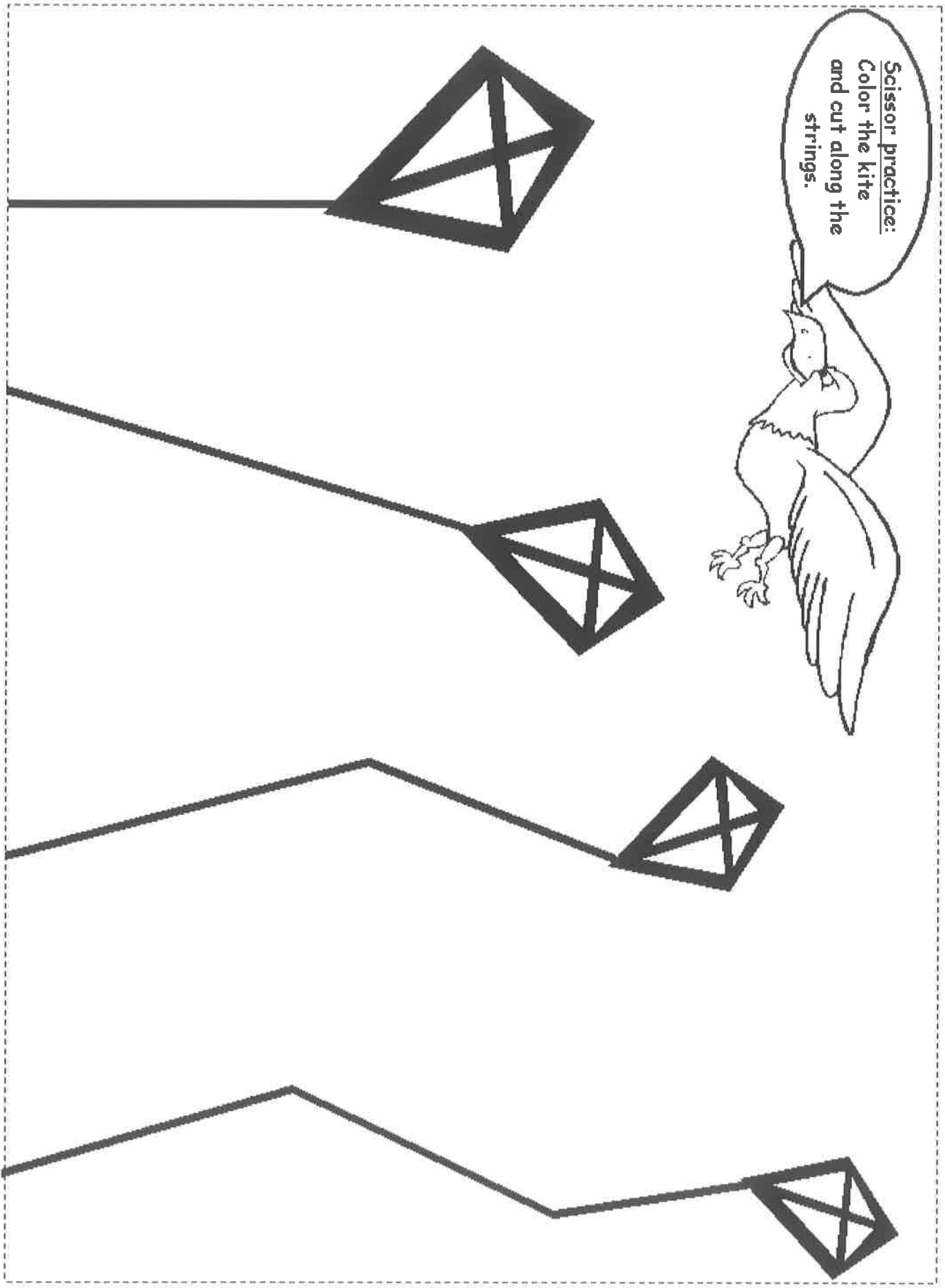
The letters are in alphabetical order.

Scissor practice:
Color the
flowers and cut
along the stems.

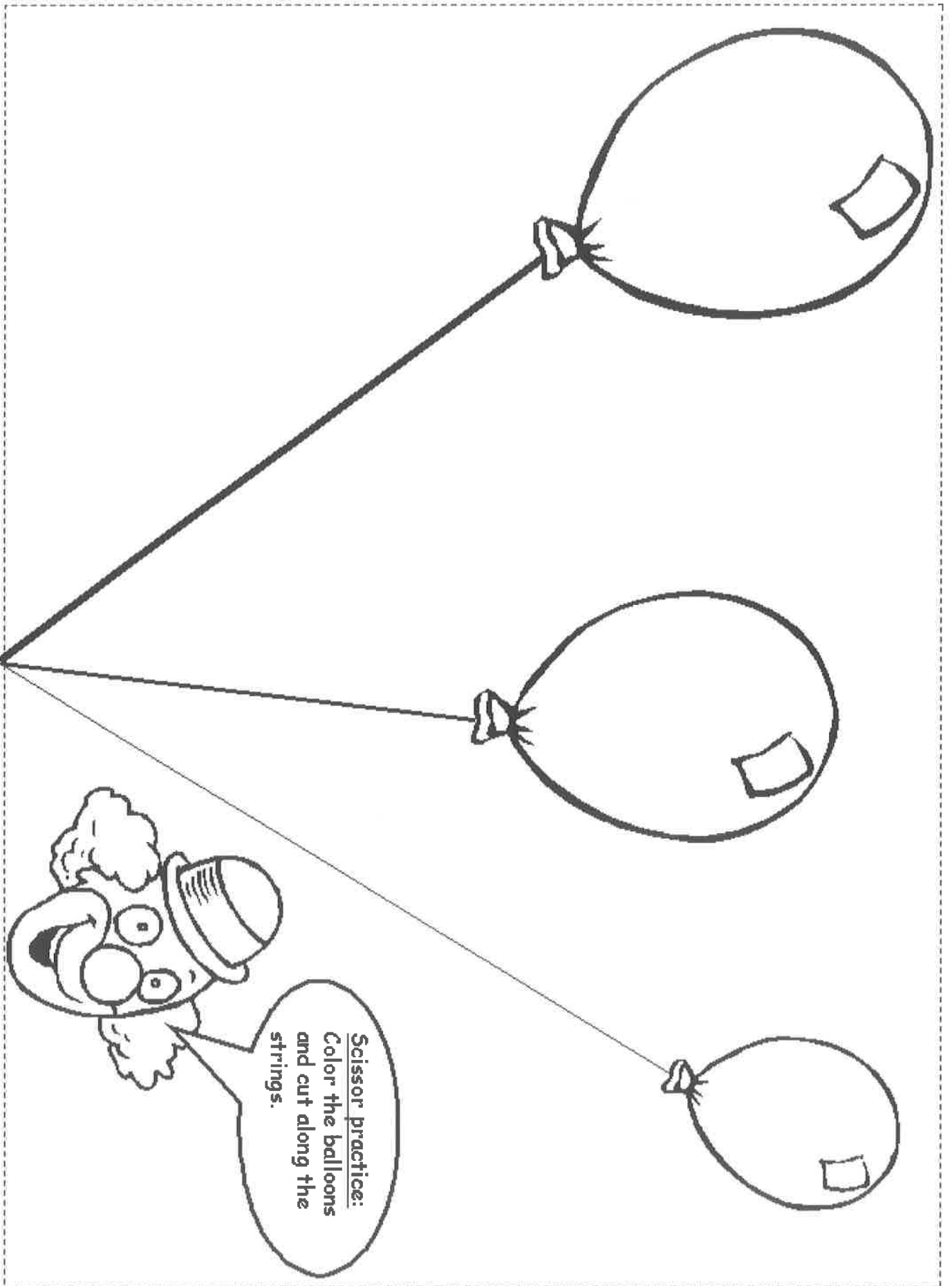


An adult should cut or rip along a ruler along the outside dotted edge before giving to the child

Scissor practice:
Color the kite
and cut along the
strings.



An adult should cut or rip along a ruler along the outside dotted edge before giving to the child



An adult should cut or rip along a ruler along the outside dotted edge before giving to the child



EVANGEL CHRISTIAN SCHOOL

39-21 Crescent Street, Long Island City, NY 11101

Pk-3 through Kindergarten

are not required to wear uniform, however,
you should purchase of gym uniform for class trips.

LANDS' END INFORMATION

To purchase gym uniforms please go to www.landsend.com. Click on "school" then click on "find my school" and insert the appropriate school number from below.

Preferred school number for elementary: 900140757

CHILD & ADOLESCENT HEALTH EXAMINATION FORM

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION

Please Print Clearly

NYC ID (OSIS)

TO BE COMPLETED BY THE PARENT OR GUARDIAN

Child's Last Name		First Name		Middle Name		Sex <input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth (Month/Day/Year) ____/____/____
Child's Address				Hispanic/Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No	Race (Check ALL that apply) <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Other		
City/Borough	State	Zip Code	School/Center/Camp Name		District Number	Phone Numbers Home _____ Cell _____ Work _____	
Health insurance (including Medicaid)? <input type="checkbox"/> Yes <input type="checkbox"/> No	Parent/Guardian Last Name		First Name		Email		
	Foster Parent						

TO BE COMPLETED BY THE HEALTH CARE PRACTITIONER

Birth history (age 0-6 yrs) <input type="checkbox"/> Uncomplicated <input type="checkbox"/> Premature: _____ weeks gestation <input type="checkbox"/> Complicated by _____		Does the child/adolescent have a past or present medical history of the following? <input type="checkbox"/> Asthma (check severity and attach MAF): <input type="checkbox"/> Intermittent <input type="checkbox"/> Mild Persistent <input type="checkbox"/> Moderate Persistent <input type="checkbox"/> Severe Persistent If persistent, check all current medication(s): <input type="checkbox"/> Quick Relief Medication <input type="checkbox"/> Inhaled Corticosteroid <input type="checkbox"/> Oral Steroid <input type="checkbox"/> Other Controller <input type="checkbox"/> None Asthma Control Status <input type="checkbox"/> Well-controlled <input type="checkbox"/> Poorly Controlled or Not Controlled					
Allergies <input type="checkbox"/> None <input type="checkbox"/> Epi pen prescribed <input type="checkbox"/> Drugs (list) _____ <input type="checkbox"/> Foods (list) _____ <input type="checkbox"/> Other (list) _____		<input type="checkbox"/> Anaphylaxis <input type="checkbox"/> Behavioral/mental health disorder <input type="checkbox"/> Congenital or acquired heart disorder <input type="checkbox"/> Developmental/learning problem <input type="checkbox"/> Diabetes (attach MAF) <input type="checkbox"/> Orthopedic injury/disability Explain all checked items above.			<input type="checkbox"/> Seizure disorder <input type="checkbox"/> Speech, hearing, or visual impairment <input type="checkbox"/> Tuberculosis (latent infection or disease) <input type="checkbox"/> Hospitalization <input type="checkbox"/> Surgery <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Addendum attached.		
Attach MAF if in-school medications needed		Medications (attach MAF if in-school medication needed) <input type="checkbox"/> None <input type="checkbox"/> Yes (list below)					

PHYSICAL EXAM Date of Exam: ____/____/____		General Appearance: <input type="checkbox"/> Physical Exam WNL NI Abnl <input type="checkbox"/> Psychosocial Development <input type="checkbox"/> HEENT <input type="checkbox"/> Lymph nodes <input type="checkbox"/> Abdomen <input type="checkbox"/> Skin <input type="checkbox"/> Language <input type="checkbox"/> Dental <input type="checkbox"/> Lungs <input type="checkbox"/> Genitourinary <input type="checkbox"/> Neurological <input type="checkbox"/> Behavioral <input type="checkbox"/> Neck <input type="checkbox"/> Cardiovascular <input type="checkbox"/> Extremities <input type="checkbox"/> Back/spine					
Height _____ cm (____ %ile)	Weight _____ kg (____ %ile)	BMI _____ kg/m ² (____ %ile)	Head Circumference (age ≤2 yrs) _____ cm (____ %ile)	Describe abnormalities:			
Blood Pressure (age ≥3 yrs) _____ / _____							

DEVELOPMENTAL (age 0-6 yrs) Validated Screening Tool Used? _____ Date Screened ____/____/____ <input type="checkbox"/> Yes <input type="checkbox"/> No Screening Results: <input type="checkbox"/> WNL <input type="checkbox"/> Delay or Concern Suspected/Confirmed (specify area(s) below): <input type="checkbox"/> Cognitive/Problem Solving <input type="checkbox"/> Adaptive/Self-Help <input type="checkbox"/> Communication/Language <input type="checkbox"/> Gross Motor/Fine Motor <input type="checkbox"/> Social-Emotional or Personal-Social <input type="checkbox"/> Other Area of Concern: _____		Nutrition < 1 year <input type="checkbox"/> Breastfed <input type="checkbox"/> Formula <input type="checkbox"/> Both ≥ 1 year <input type="checkbox"/> Well-balanced <input type="checkbox"/> Needs guidance <input type="checkbox"/> Counseled <input type="checkbox"/> Referred Dietary Restrictions <input type="checkbox"/> None <input type="checkbox"/> Yes (list below)		Hearing Data Done Results < 4 years: gross hearing ____/____/____ <input type="checkbox"/> NI <input type="checkbox"/> Abnl <input type="checkbox"/> Referred OAE ____/____/____ <input type="checkbox"/> NI <input type="checkbox"/> Abnl <input type="checkbox"/> Referred ≥ 4 yrs: pure tone audiometry ____/____/____ <input type="checkbox"/> NI <input type="checkbox"/> Abnl <input type="checkbox"/> Referred			
Describe Suspected Delay or Concern: _____		SCREENING TESTS Date Done Results Blood Lead Level (BLL) (required at age 1 yr and 2 yrs and for those at risk) ____/____/____ _____ µg/dL Lead Risk Assessment (annually, age 6 mo-6 yrs) ____/____/____ <input type="checkbox"/> At risk (do BLL) <input type="checkbox"/> Not at risk		Vision Data Done Results <3 years: Vision appears: ____/____/____ <input type="checkbox"/> NI <input type="checkbox"/> Abnl Acuity (required for new entrants and children age 3-7 years) Right ____/____/____ Left ____/____/____ <input type="checkbox"/> Unable to test Screened with Glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No Strabismus? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Child Receives EI/CPSE/CSE services <input type="checkbox"/> Yes <input type="checkbox"/> No		Hemoglobin or Hematocrit _____ g/dL _____ %		Dental Visible Tooth Decay <input type="checkbox"/> Yes <input type="checkbox"/> No Urgent need for dental referral (pain, swelling, infection) <input type="checkbox"/> Yes <input type="checkbox"/> No Dental Visit within the past 12 months <input type="checkbox"/> Yes <input type="checkbox"/> No			

CIR Number		Physician Confirmed History of Varicella Infection <input type="checkbox"/>				Report only positive immunity:																					
IMMUNIZATIONS – DATES						<table border="1"> <tr> <th>IgG Titers</th> <th>Date</th> </tr> <tr> <td>Hepatitis B</td> <td>____/____/____</td> </tr> <tr> <td>Measles</td> <td>____/____/____</td> </tr> <tr> <td>Mumps</td> <td>____/____/____</td> </tr> <tr> <td>Rubella</td> <td>____/____/____</td> </tr> <tr> <td>Varicella</td> <td>____/____/____</td> </tr> <tr> <td>Polio 1</td> <td>____/____/____</td> </tr> <tr> <td>Polio 2</td> <td>____/____/____</td> </tr> <tr> <td>Polio 3</td> <td>____/____/____</td> </tr> </table>				IgG Titers	Date	Hepatitis B	____/____/____	Measles	____/____/____	Mumps	____/____/____	Rubella	____/____/____	Varicella	____/____/____	Polio 1	____/____/____	Polio 2	____/____/____	Polio 3	____/____/____
IgG Titers	Date																										
Hepatitis B	____/____/____																										
Measles	____/____/____																										
Mumps	____/____/____																										
Rubella	____/____/____																										
Varicella	____/____/____																										
Polio 1	____/____/____																										
Polio 2	____/____/____																										
Polio 3	____/____/____																										
DTP/DTaP/DT	Tdap	MMR																									
Td		Varicella																									
Polio		Mening ACWY																									
Hep B		Hep A																									
Hib		Rotavirus																									
PCV		Mening B																									
Influenza		Other																									
HPV																											

ASSESSMENT <input type="checkbox"/> Well Child (Z00.129) <input type="checkbox"/> Diagnoses/Problems (list) _____		ICD-10 Code	RECOMMENDATIONS <input type="checkbox"/> Full physical activity <input type="checkbox"/> Restrictions (specify) _____ Follow-up Needed <input type="checkbox"/> No <input type="checkbox"/> Yes, for _____ Appt. date: ____/____/____ Referral(s): <input type="checkbox"/> None <input type="checkbox"/> Early Intervention <input type="checkbox"/> IEP <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Other _____	
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Health Care Practitioner Signature		Date Form Completed	DOHMH ONLY PRACTITIONER I.D.	
Health Care Practitioner Name and Degree (print)		Practitioner License No. and State		TYPE OF EXAM: <input type="checkbox"/> NAE Current <input type="checkbox"/> NAE Prior Year(s)
Facility Name		National Provider Identifier (NPI)		Comments:
Address		City	State	Date Reviewed: I.D. NUMBER
Telephone	Fax	Email		REVIEWER:
				FORM ID#