

Marin County Report of Health Examination for School Entry

Child's Name _____ Birthdate _____ Grade _____
 Address _____ City _____ State _____ Zip _____
 Phone _____ Medi-Cal # _____
 Reason for referral if other than pre-school physical: _____ School Nurse _____ Phone _____

HEALTH EXAMINATION MUST INCLUDE AREAS NOTED IN BOLD. (Please check if done and note results as appropriate)

Date of Exam: _____		Is child <input type="checkbox"/> New? <input type="checkbox"/> Established to your care?		Follow-Up / Referral Please indicate who will follow up HEALTH PROVIDER SCHOOL NURSE	
_____ Health and Developmental History					
_____ Nutritional Assessment	Height _____	Weight _____	B/P _____		DENTAL
_____ Physical Examination	Dental Assessment: Normal Possible caries				
_____ Blood Test for Anemia	Blood Test for Lead: No Yes Result: _____				
_____ Urine Test	Exposure to second hand smoke? No Yes				
_____ Vision Testing: Acuity Test Used:	Snellen	Titmus	VISION		
Right: 20/ _____	Left: 20/ _____	Eye muscle testing: Normal Abnormal			
_____ Referred? Yes No	_____ Student should wear eye glasses Yes No				
_____ Audiometry Screening	_____ Tympanograms (Optional)	AUDIO			

	1000	2000	3000	4000	Right _____	Left _____
Right					Referred? Yes No	
Left						

Comments: _____

ADDITIONAL INFORMATION FROM HEALTH EXAMINER: _____ **OTHER** _____

Does this child have any conditions that might concern the school? |Yes| |No|

If yes, explain condition(s) and recommendations for follow-up: _____

Are there any restrictions from physical activities? |Yes| |No|

If yes, explain _____

Does this child take any medications? |Yes| |No| Explain: _____
 (If child must take medication at school, please request and complete a medication form.)

Stamp or print examiner's name, address, phone number _____ Examiner's Signature TB skin test (PPD or clearance) required for school entry <i>regardless</i> of BCG. ___ TB assessment completed, not at risk, deferred PPD. PPD: Date given _____ Date read _____	ENTER IMMUNIZATION DATES-Shaded areas indicate minimum for admittance.					
	Polio (OPV or IPV)	[Shaded]				
	DTP / DtaP	[Shaded]				
	DT / Td					
	HIB Meningitis					
	MMR	[Shaded]				
	Hepatitis B	[Shaded]				
	Varicella	[Shaded]				
	Other					

Induration _____ mm _____ Negative _____ Positive _____ If any required immunizations were not given, list reason: _____

Chest X-Ray required if positive

Date: _____
ST34; 2/05

Normal

Abnormal

Exemption Expiration Date: _____