Marin County Report of Health Examination for School Entry

Child's Name _____ Birthdate _____ Grade _____ Medi-Cal # _____

Address _____ City _____ ZIP _____ Phone _____

Reason for referral if other than pre-K/1 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 ___ New? ___ 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** _____	
___	**Physical Examination**	**Dental Assessment [ ] Normal [ ] Possible caries**	**DENTAL**
___	**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 glasses: [ ] Yes [ ] No	
___	**Audiometry Screening**	___ Tympanograms (Optional)	**HEARING**

	1000	2000	3000	4000
Right				
Left				

Right _____ Left _____

Referred? [ ] Yes [ ] No

Comments: _____

ADDITIONAL INFORMATION FROM HEALTH EXAMINER: **OTHER**

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

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

Are there any restrictions from physical activities? [ ] No [ ] Yes

If yes, explain _____

Does this child take any medication(s)? [ ] No [ ] Yes If yes, explain _____

(If child must take medication at school, please request and complete an Authorization to Administer Medication form.)

Stamp or print examiner's name, address, phone number

_____
Examiner's Signature

TB skin test (PPD) required for school entry
(Regardless of BCG)

_____ **TB Assessment completed, not at risk, deferred PPD (not an option for CHDP/ San Rafael students)**

date given _____ Date read _____

...uration _____ mm [ ] Negative [ ] Positive

Chest X-Ray required If positive

Date _____ [ ] Normal [ ] Abnormal

Immunization Dates

Polio (OPV or IPV)					
DTP / DTaP					
DT / Td					
HIB Meningitis					
MMR					
Hepatitis B					
Varicella					
Other					

If any required immunizations were not given, list reason: _____

_____ Exemption expiration date ___/___/___

5/06