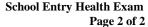


STATE OF FLORIDA School Entry Health Exam

To Parent/Guardian: Please complete and sign Part I — Child's Medical History.

State law for school entry requires a health examination by a legally qualified professional. Additional requirements may be determined by local school districts.

(Please I		First, Middle)		Birth Date	Sex						
Address (S	treet)			School	Grade						
City and ZIP Code Home Telephone Number				Parent/Guardian (Last Middle)							
City and 22	n couc		frome receptione realiser	rarent ouarthan (East Andree)							
		P	PART I — CHILD'S MI	EDICAL HISTORY							
		n: Please check answers to		elow in the column on the le							
(Please exp	lain any	"Yes" answers in the space	provided below.)								
1. Yes	No	No Any concerns about general health (eating and sleeping bits, weight, etc.)?									
2. Yes	No	Any other specific illness or social/emotional or behaviors oblems?									
3. Yes	No	Any <u>allergies</u> (food, insects, medication, etc.)									
4. Yes	No	Any prescription medication (daily or oc									
5. Yes	No	Any problems with vision, hearing, or such (glasses, explanates, explanates, hearing pids)?									
6. Yes	No	Any hospitalization, operation, or major less (specify blem)?									
7. Yes	No	Any significant injury or accident (specify blem)?									
8. Yes											
To Parent/	Guardia	n: Please explain any "Yes"	"answe to yove.								
provided a school hea \times				f of this school and any school hear my child's health and education Dai	nal needs.						
Partners	r S	chool Rea ess Recor		dergarten and Kindergarten							
To Par	Juardia	: Please obtain the se	list w in order to fi	nd any problems. Please work with y							
				school. (These services are recomm							
Date of	m:	-5 year		Please describe any corrective action for any problems detected and any accommodations required.							
Results of			a	ny accommodations required.							
results of											
Health Car	re Provid	er:	_								
			nologist 🗌								
2. Compreh		ental E on	P	lease describe any corrective action	for any problems detected and						
Date of Exam:				any accommodations required.							
Results of	Exam:										
Dentist: -											
3. Hearing S	Screenin	, , , , , , , , , , , , , , , , , , ,		Please describe any corrective action for any problems detected and							
Date of Ex			a	ny accommodations required.							
Results of	Exam:										
Health Car	re Provid	er:									



Year



Name of Child (Last, First, Middle)

Birth Date

PART II — MEDICAL EVALUATION												
To be completed and signed by the Health Care Provider ONLY:												
The child named above has had a complete history and physical exam on the following date:												
. D. L	(Exam must be with	in one year of enrolln	nent)		Month	Day						
Screening Results: Height:Weight:	BMI%:_	B/P:_	Hct/	Hgb:	Urinalysis:		s:					
Vision - Without Glasses	Right 20/	Dort 20/	Passed Failed Referred	Hearing –	Passed	Failed	Referred					
Vision - With Glasses	Right 20/	I - G 20/		Hearing – Le	Passed	Failed	Referred					
Gross dental (teeth and gums)												
Recommendations (Attach	additiona. 4 h.	cary):										
(Please Check One) This child may particle (Specific on and restrict)	in school		g physical education	cation. with the following	g restriction/ada	nptation.						
Sign re/Title of Health C	are Pro	Da	te	Addre	ss (Please print	or stamp)						
\boxtimes		,	,									
Name (Please print or stam	(p)											

Tuberculosis Targeted Suidelines for Health Care Providers

Tuberculosis Infection Risk:

Review the following risks and administer a Mantoux TB skin test if child is in one or more categories. The TB test is administered <u>confidentially</u> as part of the health examination. **Do not record administration of any TB test or related information on this form.**

- Recent immigrant (< 5 years), frequent visitor to TB endemic areas
- Close contact to active TB case
- Frequent contact with adults at high-risk for disease, HIV+, homeless, incarcerated, illicit drug user
- HIV+ or have other medical conditions that increase the risk to progress from infection to disease, e.g., chronic renal failure, diabetes, hematologic or any other malignancy, weight loss > 10% of ideal body weight, on immunosuppressive medications

Active TB Disease Risk:

- Does the child exhibit signs/symptoms of tuberculosis (e.g. cough for three weeks or longer, weight loss, loss of appetite)?
- If symptoms are present, work-up or refer for TB disease evaluation.