Florida HEALTH

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 Print)

Name of Child (Last, First, Middle)		Birth Date	Sex
Address (Street)		School	Grade
City and ZIP Code	Home Telephone Number	Parent/Guardian (Last, First, Middle)	

PART I — CHILD'S MEDICAL HISTORY

To Parent/Guardian: Please check answers to questions 1 through 8 below in the column on the le
(Please explain any "Yes" answers in the space provided below.)

1. Yes	No	Any concerns about general health (eating and sleeping habits, weight, etc.)?
2. Yes	No	Any other specific illness or social/emotional or behavior problems?
3. Yes	No	Any allergies (food, insects, medication, etc.)?
4. Yes	No	Any prescription medication (daily or oc
5. Yes	No	Any problems with vision, hearing, or ch (glasses, ntacts, e bes, hearing aids)?
6. Yes	No	Any hospitalization, operation, or majo ess (specify blem)?
7. Yes	No	Any significant injury or accident (specify blem)?
8. Yes	No	Would you like to discuss an about you ild's h with a school

To Parent/Guardian: Please explain any "Yes" answe bove.

I am the parent/guardian of the child nam bove. perm ion for the information on PARTS I and II of this form provided about my chil be reviewed and ed only ff of this school and any school health personnel providing school health services istrict for the limi urpose of my child's health and educational needs.

☒ _____ _____
Signatu rent/Guardia Date

Partnership for School Rea ess Recom dations for Prekindergarten and Kindergarten

To Par Guardian: Please obt the se list w in order to find any problems. Please work with your health care provider to correct reat any problems that m your child's ity to learn in school. **(These services are recommended but not required.)**

1. Com hensive Vision Examinat -5 years of age) Date of m: Results of Health Care Provider: *(check one)* Optometrist ☐ Ophthalmologist ☐	Please describe any corrective action for any problems detected and any accommodations required.
2. Comprehensive Dental E on Date of Exam: Results of Exam: Dentist:	Please describe any corrective action for any problems detected and any accommodations required.
3. Hearing Screening Date of Exam: Results of Exam: Health Care Provider:	Please describe any corrective action for any problems detected and any accommodations required.

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: _____ Month _____ Day _____ Year

(Exam must be within one year of enrollment)

Screening Results:

Height:_____ Weight:_____ BMI%:_____ B/P:_____ Hct/Hgb:_____ _____ Urinalysis: _____

Vision - Without Glasses	Right 20/_____	Left 20/_____	Passed ☐ Failed ☐ Referred ☐	Hearing –	Passed ☐ Failed ☐ Referred ☐
Vision - With Glasses	Right 20/_____	Left 20/_____		Hearing – Le	Passed ☐ Failed ☐ Referred ☐

Gross dental (teeth and gums)	☐ Normal	☐ Abnormal	_____	R
Head/scalp/skin	☐ Normal	☐ Abnormal	_____	Refe
Eyes/Ears/Nose/Throat	☐ Normal	☐ Abnormal	_____	Refer/T
Chest/Lungs/Heart	☐ Normal	☐ Abnormal	_____	Refer/Tx:
Abdomen	☐ Normal	☐ Abnormal	_____	Refer/Tx:
Postural assessment	☐ Normal	☐ Abnorma	_____	Refer/Tx:

TB risk assessment done ☐ ***(Please review Targe esting Guideli isted belo***

This child has the following problems that may impact the educa l experience

☐ Vision ☐ Hearing ☐ Speech/Lang ☐ Phy l ☐ Social/Be al ☐ Cognitive

Specify: _____

☐ This child has a health condition that may require em ency on at schoo seizures, allergies. Specify below.

(This form will be stored in the chil Cumulative Healt older t ay be acce by both school and health personnel.)

Recommendations (Attach additiona et i sary): _____

(Please Check One)

☐ This child may part ate fu school activitie luding physical education.

☐ This child may partic in schoo ties includi ysical education with the following restriction/adaptation.

(Sp on and restricti _____

Sig re/Title of Health Care Pr er	Date	Address (Please print or stamp)
⊠	/ /	
Name (Please print or stamp)		

Tuberculosis Targeted Guidelines 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 confidentially 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.