

STATE OF FLORIDA School Entry Health Exam

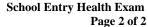
To Parent/Guardian: Please complete and sign Part I — Child's Medical History.

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)	
P	ART I — CHILD'S ME	DICAL HISTORY	
Parent/Guardian: Please check answers to ease explain any "Yes" answers in the space. 1. Yes No Any concerns about get 2. Yes No Any other specific illne. 3. Yes No Any allergies (food, ins.). 4. Yes No Any prescription medic. 5. Yes No Parent/Guardian: Please ease.	e provided below.) meral health (eating and ss or social/emotional o ects, medication, etc.)? ation (daily or occasion	sleeping habits, weight, etc.)? r behavioral problems? ally)?	
m the parent/guardian of the child named ovided about my child to be reviewed and nool health services in the district for the li	utilized only by the staf	f of this school and any school health	personnel providing
Signature of Paren	t/Guardian	Date	
rtnership for School Readiness Recomn	nendations for Prekind	ergarten and Kindergarten	

To Parent/Guardian: Please obtain the services listed below in order to find any problems. Please work with your health care provider to correct or treat any problems that may reduce your child's ability to learn in school. (**These services are recommended but not required.**)

1. Comprehensive Vision Examination (3-5 years of age)





Birth Date Name of Child (Last, First, Middle) 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: (Exam must be within one year of enrollment) Month Day Year Screening Results: B/P: Height: Weight: BMI%: Hct/Hgb: Lead: Urinalysis: Passed Left 20/ Failed Vision - Without Glasses Right 20/ Hearing - Right Passed Referred [Failed Vision - With Glasses Right 20/ Left 20/ Hearing - Left Passed Failed Referred Referred Gross dental (teeth and gums) Normal ☐ Abnormal Refer/Tx: Head/scalp/skin Normal Abnormal Refer/Tx: Eyes/Ears/Nose/Throat Normal Abnormal Refer/Tx: Normal Chest/Lungs/Heart Abnormal Refer/Tx: Abdomen Normal Abnormal Refer/Tx: Normal Postural assessment Refer/Tx: (Please review Targeted Testing Guidelines listed below.) TB risk assessment done This child has the following problems that may impact the educational experience: ☐ Vision Hearing ☐ Speech/Language Physical ☐ Social/Behavioral ☐ Cognitive

This child has a health condition that may require emergency action at school, e.g. seizures, allergies. Specify below. (This form will be stored in the child's Cumulative Health Folder and may be accessed by both school and health personnel.)

(Please Check One)

Recommendations (Attach additional sheet if necessary):

Specify: