

**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 left.

(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 behavioral problems?
3. Yes ___ No ___ Any allergies (food, insects, medication, etc.)?
4. Yes ___ No ___ Any prescription medication (daily or occasionally)?
5. Yes ___ No ___ Any problems with vision, hearing, or speech (glasses, contacts, ear tubes, hearing aids)?
6. Yes ___ No ___ Any hospitalization, operation, or major illness (specify problem)?
7. Yes ___ No ___ Any significant injury or accident (specify problem)?
8. Yes ___ No ___ Would you like to discuss anything about your child's health with a school nurse?

To Parent/Guardian: Please explain any "Yes" answers from above.

I am the parent/guardian of the child named above. I give permission for the information on PARTS 1 and 2 of this form provided about my child to be reviewed and utilized only by the staff of this school and any school health personnel providing school health services in the district for the limited purpose of meeting my child's health and educational needs.

Signature of Parent/Guardian

Date

Partnership for School Readiness Recommendations for Prekindergarten 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) Date of Exam: _____ Results of Exam: _____ Health Care Provider: <i>(check one)</i> Optometrist Ophthalmologist	Please describe any corrective action for any problems detected and any accommodations required.
2. Comprehensive Dental Examination 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.

BROWARD COUNTY PUBLIC SCHOOLS PRESCHOOL MEDICAL RECORD

Child's Name _____	Birth Date _____ Sex _____ Race _____
Address _____ Street City Zip	Please check child's current medical coverage: Florida <input type="checkbox"/> Medicaid <input type="checkbox"/> Insurance <input type="checkbox"/> Kidcare <input type="checkbox"/> None
Telephone _____	Name of child's Dr./Clinic _____
School _____	

HEALTH HISTORY/ASSESSMENT

Check all diseases/health problems your child has had in the **past**:

Chicken Pox	Premature Birth	Ear Infections
Rheumatic Fever	Heart	Convulsions/Seizure

Other serious illness or injury _____
Explain _____

Check all the health problems your child has **now**:

Allergies	Dental	Seizures	Kidney	Anemia	Asthma	Ear Tubes	Diabetes
Speech	Bladder	Hearing	Vision	Heart	Hemophilia	Sickle Cell	Trait

Other _____ Explain _____
For allergies/asthma, list causes/triggers _____

Does anyone in your household smoke? Yes No
Does your child need assistance or is he/she restricted from physical activities due to health problems? Yes No
Explain _____

Check all the health problems your child experiences **frequently**:

Bronchitis	Coughing	Colds	Diarrhea	Sore Throats	Stomach Pain	Injuries
Rashes	Vomiting	Constipation	Nose Bleeds	Trouble Urinating	Ear Infections	

Explain, if necessary _____

Is your child taking medication? Yes No
If yes, what medicine and when given? _____

NUTRITION INFORMATION

(Check "Yes" or "No" – Explain as needed)

1. Is there any food your child should not eat for medical, religious, or personal reasons? Yes No
2. Is your child on a special diet? Yes No
3. Do you have any concerns about what your child eats? Yes No
4. Does your child take vitamin and mineral supplements? If yes, what kind are they? Yes No
5. What kind of food does your child Like _____ Dislike _____
6. Does your child eat or chew things that aren't food? Yes No
7. Does your child have trouble chewing or swallowing? Yes No
8. Has there been a big change in your child's appetite recently? Yes No
9. Does your child take a bottle? Yes No

DEVELOPMENTAL HISTORY

Approximately at what **age** did your child:

a) Sit up without help _____	d) Dress self _____
b) Crawl _____	e) Feed self _____
c) Walk _____	f) Learn to use toilet _____
d) Talk _____	g) Understand what was said to him/her _____

I voluntarily give consent for my child to receive services that may include classroom observations, mental health consultation and screening in the following areas: hearing, vision, nutrition, development, social-emotional and dental including follow-up care. I further agree to allow my child to be transported by school bus to access services, which include dental care, swimming lessons and other field trip.

_____ Signature of Parent/Guardian

_____ Date