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: *(check one)* 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

Telephone _____

School_____

Please check child's current medical coverage:

☐ Medicaid ☐ Insurance ☐ Florida Kidcare ☐ None

Name of child's Dr./Clinic_____

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 ____
b) Crawl ____
c) Walk ____
d) Talk ____
d) Dress self ____
e) Feed self ____
f) Learn to use toilet ____
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**