



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)

Form with fields: 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.

Three horizontal lines for writing answers to the questions above.

I am the parent/guardian of the child named above. I give permission for the information on PARTS I and II 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.

[X] \_\_\_\_\_ 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.)

Table with 2 columns: Exam type (Vision, Dental, Hearing) and Description of corrective actions. Includes fields for Date of Exam, Results of Exam, and Health Care Provider.



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:

(Exam must be within one year of enrollment)

Month Day Year

Screening Results:

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

Table with 4 columns: Vision - Without Glasses, Vision - With Glasses, Hearing - Right, Hearing - Left. Each cell contains checkboxes for Passed, Failed, Referred.

Gross dental (teeth and gums) Head/scalp/skin Eyes/Ears/Nose/Throat Chest/Lungs/Heart Abdomen Postural assessment. Each item has checkboxes for Normal/Abnormal and a Refer/Tx line.

TB risk assessment done (Please review Targeted Testing Guidelines listed below.)

This child has the following problems that may impact the educational experience:

- Checkboxes for Vision, Hearing, Speech/Language, Physical, Social/Behavioral, Cognitive.

Specify:

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.)

Recommendations (Attach additional sheet if necessary):

(Please Check One)

- Checkboxes for: This child may participate fully in school activities including physical education. This child may participate in school activities including physical education with the following restriction/adaptation.

(Specify reason and restriction)

Signature/Title of Health Care Provider, Date, Address (Please print or stamp)

Tuberculosis Targeted Testing 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.