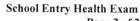


STATE OF FLORIDA School Entry Health Exam

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)						
Pz	ART I — CHILD'S MEI	DICAL HISTORY						
To Parent/Guardian: Please check answers to	questions 1 through 8 bel							
Please explain any "Yes" answers in the space provided below.) 1. Yes \(\sum_{\text{No}}								
2. Yes No Any other specific illne 3. Yes No Any allergies (food, ins 4. Yes No Any prescription medic	ss or social/emotional or ects, medication, etc.)? ation (daily or occasional	behavioral problems?						
5. Yes No Any problems with visi 6. Yes No Any hospitalization, op	on, hearing, or speech (geration, or major illness	classes, contacts, ear tubes, hearing a (specify problem)?	ids)?					
7. Yes No Any significant injury of 8. Yes No Would you like to discu	or accident (specify probusts anything about your	lem)? child's health with a school nurse?						
Γο Parent/Guardian: Please explain any "Yes"								
am the parent/guardian of the child named provided about my child to be reviewed and school health services in the district for the li	utilized only by the staff mited purpose of meetin	of this school and any school health g my child's health and educational	personnel providing					
Signature of Paren		Date						
Partnership for School Readiness Recomm								
Fo Parent/Guardian: Please obtain the services correct or treat any problems that may reduce your	listed below in order to find r child's ability to learn in s	any problems. Please work with your lackyool. (These services are recommend	health care provider to					
Comprehensive Vision Examination (3-5 yea Date of Exam:	rs of age) Ple	ase describe any corrective action for accommodations required.	any problems detected and					
Results of Exam:								
Health Care Provider:								
(check one) Optometrist Ophthalm	nologist 🗌							
2. Comprehensive Dental Examination			any problems detected and					
Date of Exam: Results of Exam:	1	any accommodations required.						
Dentist:								
3. Hearing Screening		ase describe any corrective action for	any problems detected and					
Date of Exam:	accommodations required.	processes detected unit						
Results of Exam:								
Health Care Provider:								





Name of Child (Last, First, Middle)			Birth Dat	e	Page 2 of
	RT II — MEDICAL	EVALUATION			
To be completed and signed by the Health Care Prov The child named above has had a complete history a		n the following date:			
(Exam must be within one ye		n the following date:	Month	Day	Year
Screening Results:					
Height: BMI%:	B/P:	Hct/Hgb:	Lead:	Urinal	ysis:
Vision - Without Glasses Right 20/ Left 2		Hearing – Right	Passed	Failed	Referred
Vision - With Glasses Right 20/ Left 2	Failed Referred	Hearing – Left	Passed	Failed	Referred
Gross dental (teeth and gums) Normal Head/scalp/skin Normal Eyes/Ears/Nose/Throat Normal Chest/Lungs/Heart Normal	Abnormal Abnormal Abnormal The Wargeted Testing of the educational exage Physical Abnormal A	at school, e.g. seizures, a	school and he	alth personn	nel.)
	luding physical educ	cation with the following			
Signature/Title of Health Care Provider	Date	Addres	s (Please print	or stamp)	
x	//				
Name (Please print or stamp)					
Tuberculosis Targeted Testing Guidelines for Health Tuberculosis Infection Risk: Review the following risks and administer a Mantoux TB part of the health examination. Do not record administra Recent immigrant (< 5 years), frequent vi Close contact to active TB case Frequent contact with adults at high-risk to HIV+ or have other medical conditions the diabetes, hematologic or any other malign	skin test if child is in ation of any TB test or isitor to TB endemic a for disease, HIV+, hor nat increase the risk to	r related information on areas meless, incarcerated, illicoprogress from infection to	it drug user	chronic renal	failure.

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.

Active TB Disease Risk: