Marin County Report of Health Examination for School Entry

Child's Name _____ Birthdate _____ Grade _____ Medi-Cal # _____

Address _____ City _____ ZIP _____ Phone _____

Reason for referral if other
than pre-school physical: _____ School Nurse _____ Phone _____

HEALTH EXAMINATION MUST INCLUDE AREAS NOTED IN BOLD. (Please check if done and note results as appropriate)

Date of Exam: _____ Is child ___New? ___ Established to your care?

Follow-Up / Referral
Please indicate who will follow-up

		HEALTH PROVIDER	SCHOOL NURSE
___	**Health and Developmental History**		
___	**Nutritional Assessment**	**Height _____ Weight _____ B/P _____**	
___	**Physical Examination**	**Dental Assessment [ ]Normal [ ]Possible caries**	**DENTAL**
___	**Blood Test for Anemia**	Blood Test for Lead: [ ]No [ ]Yes Result: _____	
___	**Urine Test**	Exposure to second hand smoke? [ ]No [ ]Yes	

___ **Vision Testing: Acuity Test Used: [ ] Snellen [ ] Titmus** **VISION**

Right: 20/ ____ Left: 20/ ____ Eye muscle testing: [ ]Normal [ ]Abnormal

Referred? [ ]Yes [ ]No Student should wear glasses: [ ]Yes [ ]No

___ **Audiometry Screening** ___ Tympanograms (Optional) **AUDIO**

	1000	2000	3000	4000
Right				
Left				

Right _____ Left _____

Referred? [ ]Yes [ ]No

Comments: _____

ADDITIONAL INFORMATION FROM HEALTH EXAMINER: **OTHER**

Does this child have any conditions that might concern the school? [ ] No [ ] Yes

If yes, explain condition(s) and recommendations for follow-up: _____

Are there any restrictions from physical activities? [ ]No [ ]Yes

If yes, explain _____

Does this child take any medication(s)? [ ]No [ ]Yes If yes, explain _____

(If child must take medication at school, please request and complete a medication form.)

Stamp or print examiner's name, address, phone number

Examiner's Signature

TB skin test (PPD) required for school entry
unless BCG given within past 12 mos.

Date given ___/___/___ Date read ___/___/___

Induration _____ mm [ ]Negative [ ]Positive

Chest X-Ray required If positive

Date ___/___/___ [ ] Normal [ ]Abnormal

Immunization Dates

Polio (OPV or IPV)					
DTP / DTaP					
DT / Td					
HIB Meningitis					
MMR					
Hepatitis B					
Varicella					
Other					

If any required immunizations were not given, list reason: _____

_____ Exemption expiration date ____/____/___