Marin County Report of Health Examination for School Entry

Child's Name _____ Birthdate _____ Grade _____

Address _____ City _____ State ____ Zip __

Phone _____ Medi-Cal # _____

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** _____ **DENTAL**		
_____ **Physical Examination** **Dental Assessment:** | | **Normal** | | **Possible caries**		
_____ **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 eye 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? \|Yes\| \|No\|

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

Are there any restrictions from physical activities? \|Yes\| \|No\|

If yes, explain _____

Does this child take any medications? \|Yes\| \|No\| 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 or clearance) required for school entry *regardless* of BCG.
___TB assessment completed, not at risk, deferred PPD.
PPD: Date given _____ Date read _____

Induration ____mm ____ Negative ____ Positive

ENTER IMMUNIZATION DATES-**Shaded areas indicate minimum for admittance.**

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

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

Chest X-Ray required if positive

Date: _____ Normal ☐ Abnormal ☐ Exemption Expiration Date: _____

ST34; 2/05