REPORT OF HEALTH EXAMINATION FOR SCHOOL ENTRY

To protect the health of children, California law requires a health examination on school entry. Please have this report filled out by a health examiner and return it to the school. The school will keep and maintain it as confidential information.

PART I TO BE FILLED OUT BY A PARENT OR GUARDIAN

CHILD'S NAME—Last	First	Middle	BIRTH DATE—Month/Day/Year

ADDRESS—Number, Street	City	ZIP code	SCHOOL

PART II TO BE FILLED OUT BY HEALTH EXAMINER

HEALTH EXAMINATION

NOTE: All tests and evaluations except the blood lead test must be done after the child is 4 years and 3 months of age.

REQUIRED TESTS/EVALUATIONS	DATE (mm/dd/yy)
Health History	/ /
Physical Examination	/ /
Dental Assessment	/ /
Nutritional Assessment	/ /
Developmental Assessment	/ /
Vision Screening	/ /
Audiometric (hearing) Screening	/ /
TB Risk Assessment and Test, if indicated	/ /
Blood Test (for anemia)	/ /
Urine Test	/ /
Blood Lead Test	/ /
Other	/ /

IMMUNIZATION RECORD

Note to Examiner: Please give the family a completed or updated yellow California Immunization Record.
Note to School: Please record immunization dates on the blue California School Immunization Record (PM 286).

VACCINE	DATE EACH DOSE WAS GIVEN				
	First	Second	Third	Fourth	Fifth
POLIO (OPV or IPV)					
DtaP/DTP/DT/Td (diphtheria, tetanus, and [acellular] pertussis) OR (tetanus and diphtheria only)					
MMR (measles, mumps, and rubella)					
HIB MENINGITIS (Haemophilus Influenzae B) (Required for child care/preschool only)					
HEPATITIS B					
VARICELLA (Chickenpox)					
OTHER (e.g., TB Test, if indicated)					
OTHER					

PART III ADDITIONAL INFORMATION FROM HEALTH EXAMINER *(optional)* *and* RELEASE OF HEALTH INFORMATION BY PARENT OR GUARDIAN

RESULTS AND RECOMMENDATIONS

Fill out if patient or guardian has signed the release of health information.

☐ Examination shows no condition of concern to school program activities.

☐ Conditions found in the examination or after further evaluation that are of importance to schooling or physical activity are: *(please explain)*

I give permission for the health examiner to share the additional information about the health check-up with the school as explained in Part III.

☐ Please check this box if you ***do not*** want the health examiner to fill out Part III.

Signature of parent or guardian ____________ Date ________

Name, address, and telephone number of health examiner

Signature of health examiner ____________ Date ________

If your child is unable to get the school health check-up, call the Child Health and Disability Prevention (CHDP) Program in your local health department. If you do not want your child to have a health check-up, you may sign the waiver form (PM 171 B) found at your child's school.

CHDP website: www.dhcs.ca.gov/services/chdp

San Marino Unified School District

1665 West Drive, San Marino, CA 91108

Report of Eye and Audiology Examination

Name of child: ______________________________ Birthdate: ____________________

EYE EXAMINATION

VISUAL ACUITY

Without Lenses:
R. 20 / L. 20 /
Both: 20 /

With Lenses:
R. 20 / L. 20 /
Both: 20 /

GLASSES

_____ Not Prescribed
_____ Prescribed
_____ To be worn all the time
_____ To be worn for close work only
_____ To be worn for distance only

Is preferential seating recommended? ______________________________

Other recommendations or suggestions: ______________________________

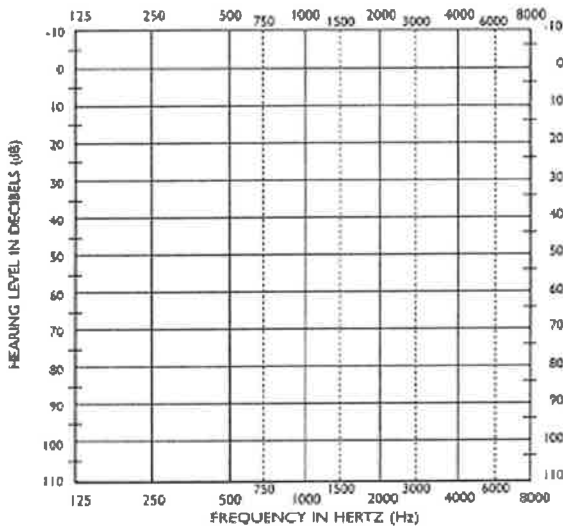
____

Physician's printed name: ______________________________

Address: ______________________________ Telephone: ____________________

- -

AUDIOLOGY EXAMINATION



AUDIOGRAM KEY	RIGHT	LEFT
AC Unmasked	○	X
AC Masked	△	□
BC Mastoid Unmasked	<	>
BC Mastoid Masked	[	]
BC Forehead Masked	˥	Γ

Both	
BC Forehead Unmasked	V
Sound Field	S

	Right Ear	Left Ear
S.R.T.		
Discrim		
MCL		
UCL		

Findings: ______________________________
____
____

Any special instructions:
____
____
____

Preferential seating?
____
____

HEIGHT: ____________________ Date: ____________________

WEIGHT: ____________________ Physician's signature: ______________________________

Parents: This form is to be filled out and signed by a physician.