



**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)	

**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.

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**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.**



\_\_\_\_\_

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.)**

1. Comprehensive Vision Examination (3-5 years of age) Date of Exam: _____ Results of Exam: _____  Health Care Provider: _____ (check one) Optometrist <input type="checkbox"/> Ophthalmologist <input type="checkbox"/>	Please describe any corrective action for any problems detected and any accommodations required.
2. Comprehensive Dental Examination Date of Exam: _____ Results of Exam: _____  Dentist: _____	Please describe any corrective action for any problems detected and any accommodations required.
3. Hearing Screening Date of Exam: _____ Results of Exam: _____  Health Care Provider: _____	Please describe any corrective action for any problems detected and any accommodations required.



Name of Child (Last, First, Middle)	Birth Date
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**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: \_\_\_\_\_

Vision - Without Glasses	Right 20/_____	Left 20/_____	Passed <input type="checkbox"/>	Failed <input type="checkbox"/>	Referred <input type="checkbox"/>	Hearing – Right	Passed <input type="checkbox"/>	Failed <input type="checkbox"/>	Referred <input type="checkbox"/>
Vision - With Glasses	Right 20/_____	Left 20/_____	Failed <input type="checkbox"/>	Referred <input type="checkbox"/>		Hearing – Left	Passed <input type="checkbox"/>	Failed <input type="checkbox"/>	Referred <input type="checkbox"/>

- |                               |                                 |                                   |       |                 |
|-------------------------------|---------------------------------|-----------------------------------|-------|-----------------|
| Gross dental (teeth and gums) | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal | _____ | Refer/Tx: _____ |
| Head/scalp/skin               | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal | _____ | Refer/Tx: _____ |
| Eyes/Ears/Nose/Throat         | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal | _____ | Refer/Tx: _____ |
| Chest/Lungs/Heart             | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal | _____ | Refer/Tx: _____ |
| Abdomen                       | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal | _____ | Refer/Tx: _____ |
| Postural assessment           | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal | _____ | Refer/Tx: _____ |

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

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

- 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)

- 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) \_\_\_\_\_

<b>Signature/Title of Health Care Provider</b>	<b>Date</b>	<b>Address (Please print or stamp)</b>
<input checked="" type="checkbox"/>	___/___/___	
<b>Name (Please print or stamp)</b>		

**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.