School Entry Health Exam

To Parent/Guardian: Please complete and sign Part I — Child's Medical History.
School entry requires a health examination by a legally qualified professional.

Name of Child (Last, First, Middle)		**Birth Date**	**Sex**
Address (Street)			**Grade**
City and PIN 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.)

Yes		No		Any concerns about general health (eating and sleeping habits, weight, etc.)?
Yes		No		Any other specific illness or social/emotional or behavioral problems?
Yes		No		Any allergies (food, insects, medication, etc.)?
Yes		No		Any prescription medication (daily or occasionally)?
Yes		No		Any problems with vision, hearing, or speech (glasses, contacts, ear tubes, hearing aids)?
Yes		No		Any hospitalization, operation, or major illness (specify problem)?
Yes		No		Any significant injury or accident (specify problem)?
Yes		No		Would you like to discuss anything about your child's health with a school nurse?
Yes		No		Any history of skin diseases or other communicable diseases?

To Parent/Guardian: Please explain any "Yes" answers from above.

_____

_____

_____

_____

_____

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

PART II — MEDICAL EVALUATION

To be completed and signed by the Doctor ONLY

The child named above has had a complete history and physical exam on the following dates : _____

Screening Results :

Height :	Weight :		BMI%	BP :	Hct/Hgh:
Lead :	Urinalysis:				
Vision – Without Glasses	Right :	Left :	Passed :	Hearing – Right	Passed :
Vision – With Glasses:	Right :	Left :	Failed :	Hearing - Left	Failed :

Gross dental (teeth and gums)	Normal		Abnormal		Remarks	
Head/scalp/skin	Normal		Abnormal		Remarks	
Eyes/Ears/Nose/Throat	Normal		Abnormal		Remarks	
Chest/Lungs/Heart	Normal		Abnormal		Remarks	
Abdomen	Normal		Abnormal		Remarks	
Postural assessment	Normal		Abnormal		Remarks	

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) _____

_____

Signature/Title of Health Care Provider	**Date**	**Address (Please print or stamp)**
	/ /	
Name (Please print or stamp)		

Tuberculosis Infection Risk:

Review the following risks and administer a Mantoux TB skin test if necessary

1. Frequent visitor to TB endemic areas
2. Close contact to active TB case
3. Frequent contact with adults at high-risk for disease, HIV+, homeless, incarcerated, illicit drug user
4. 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:

1. Does the child exhibit signs/symptoms of tuberculosis (e.g. cough for three weeks or longer, weight loss, loss of appetite)?
2. If symptoms are present, work-up or refer for TB disease evaluation.

National Immunization Schedule		
For Infants		
Vaccine	**When to give**	**Yes or No**
BCG	At birth or as early as possible till one year of age	
Hepatitis B Birth dose	At birth or as early as possible within 24 hours	
OPV Birth dose	At birth or as early as possible within the first 15 days	
OPV 1,2 & 3	At 6 weeks, 10 weeks & 14 weeks	
IPV (inactivated Polio Vaccine)	14 weeks	
Pentavelant 1,2 & 3	At 6 weeks, 10 weeks & 14 weeks	
Rota Virus Vaccine	At 6 weeks, 10 weeks & 14 weeks	
Measles 1st Dose	9 completed months-12 months. (give up to 5 years if not received at 9-12 months age)	
Vitamin A, 1st Dose	At 9 months with measles	
DPT 1st booster	16-24 months	
OPV Booster	16-24 months	
Measles 2nd dose	16-24 Months	
Vitamin A (2nd to 9thdose)	16 months with DPT/OPV booster, then, one dose every 6 month up to the age of 5 years)	
DPT 2nd Booster	5-6 years	
TT	10 years & 16 years	