PREVENTATIVE HEALTH CARE EXAMINATION FORM

All local boards of education shall require a preventative health care examination of each child first entering a Kentucky public school within a period of twelve (12) months prior to initial admission to school and within one (1) year prior to entry to sixth grade. Local school boards may extend this time not to exceed two (2) months. (702 KAR 1:160)

PLEASE COMPLETE THE IDENTIFYING INFORMATION AND RECORDS

IDENTIFYING INFORMATION

Student Name: ________________________________ Gender: M F Grade: ________________
Date of Birth: ___________________________ Age: _____ yrs _____ months Preferred Language: ________________
Parent or Guardian Name: ________________________________

RECORD OF IMMUNIZATIONS TO BE REPORTED ON IMMUNIZATION CERTIFICATE FORM, EPID 230.

MEDICAL HISTORY

Allergies:

__________________________________________
__________________________________________
__________________________________________

Current Prescribed Medications to be taken daily at school:

__________________________________________
__________________________________________
__________________________________________

Significant Historical Information:

__________________________________________
__________________________________________
__________________________________________

SCREENING RESULTS:

Height: _____ ft ______ inches Weight BMI: ______ BMI%: ______ B/P: ______

<table>
<thead>
<tr>
<th>Vision</th>
<th>Right 20/________</th>
<th>Passed</th>
<th>Failed</th>
<th>Referred</th>
<th>Hearing – Right</th>
<th>Passed</th>
<th>Failed</th>
<th>Referred</th>
<th>Hearing - Left</th>
<th>Passed</th>
<th>Failed</th>
<th>Referred</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Left 20/________</td>
<td>Passed</td>
<td>Failed</td>
<td>Referred</td>
<td></td>
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<td></td>
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<td></td>
</tr>
</tbody>
</table>

Optional: Hct/HGB: ____________________________ Lead: ____________________________ Urinalysis: ____________________________

<table>
<thead>
<tr>
<th>Gross dental (teeth and gums)</th>
<th>Normal</th>
<th>Abnormal</th>
<th>Refer/Tx:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head/scalp/skin</td>
<td>Normal</td>
<td>Abnormal</td>
<td>Refer/Tx:</td>
</tr>
<tr>
<td>Eyes/Ears/Nose/Throat</td>
<td>Normal</td>
<td>Abnormal</td>
<td>Refer/Tx:</td>
</tr>
<tr>
<td>Chest/Lungs/Heart</td>
<td>Normal</td>
<td>Abnormal</td>
<td>Refer/Tx:</td>
</tr>
<tr>
<td>Abdomen</td>
<td>Normal</td>
<td>Abnormal</td>
<td>Refer/Tx:</td>
</tr>
<tr>
<td>Scoliosis assessment</td>
<td>Normal</td>
<td>Abnormal</td>
<td>Refer/Tx:</td>
</tr>
</tbody>
</table>

(Over)
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.

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)

ANTICIPATORY GUIDELINES

Discussed and/or handout given

☐ SCHOOL READINESS
  • Establish routines
  • After-school care/activities
  • Friends
  • Bullying
  • Communicate with teachers

☐ ORAL HEALTH
  • Regular dentist visits
  • Brushing/Flossing
  • Fluoride

☐ MENTAL HEALTH
  • Family time
  • Anger management
  • Discipline for teaching not punishment
  • Limit TV, computer

☐ SAFETY
  • Sexual safety
  • Pedestrian safety
  • Safety helmets
  • Swimming safety
  • Fire escape plan
  • Smoke/carbon monoxide detectors
  • Guns
  • Sun
  • Appropriately restrained in all vehicles

☐ NUTRITION AND PHYSICAL ACTIVITY
  • Healthy weight
  • Well-balanced diet, including breakfast
  • Fruits, vegetables, whole grains, dairy
  • 60 minutes of exercise/day

Additional comments or recommendations:

Signed: ___________________________  Date: ___________________________

Physician/APRN/PA/EPDT Provider

Address: ___________________________  Telephone: ___________________________