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></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<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
  • 60 minutes of exercise/day
  • 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

Additional comments or recommendations: __________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Signed: ____________________________  Date: ____________________________

Physician/APRN/PA/EPSDT Provider

Address: ____________________________  Telephone: ____________________________