

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:

BP: _____ Height: _____ (ft.) _____ (inches) Weight _____ lbs. BMI _____ BMI% _____

| | | | | | | |
|--------|----------------|-----------------------------------|-----------------|---------------------------------|---------------------------------|-----------------------------------|
| Vision | Right 20/_____ | Passed <input type="checkbox"/> | Hearing – Right | Passed <input type="checkbox"/> | Failed <input type="checkbox"/> | Referred <input type="checkbox"/> |
| | Left 20/_____ | Failed <input type="checkbox"/> | | Passed <input type="checkbox"/> | Failed <input type="checkbox"/> | Referred <input type="checkbox"/> |
| | | Referred <input type="checkbox"/> | Hearing - Left | Passed <input type="checkbox"/> | Failed <input type="checkbox"/> | Referred <input type="checkbox"/> |

Optional: Hct/HGB: _____ Lead: _____ Urinalysis: _____

- General appearance Normal Abnormal _____ Refer/Tx: _____
- Gross dental (teeth and gums) Normal Abnormal _____ Refer/Tx: _____
- Head/scalp/skin Normal Abnormal _____ Refer/Tx: _____
- Eyes/Ears/Nose/Throat Normal Abnormal _____ Refer/Tx: _____
- Chest/Lungs/Heart Normal Abnormal _____ Refer/Tx: _____
- Abdomen/Genitalia Normal Abnormal _____ Refer/Tx: _____
- Extremities/back Normal Abnormal _____ Refer/Tx: _____
- Neuro Normal Abnormal _____ Refer/Tx: _____

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

- | | |
|---|--|
| <input type="checkbox"/> SCHOOL READINESS <ul style="list-style-type: none"> • Establish routines • After-school care/activities • Friends • Bullying • Communicate with teachers | <ul style="list-style-type: none"> • 60 minutes of exercise/day <input type="checkbox"/> ORAL HEALTH <ul style="list-style-type: none"> • Regular dentist visits • Brushing/Flossing • Fluoride |
| <input type="checkbox"/> MENTAL HEALTH <ul style="list-style-type: none"> • Family time • Anger management • Discipline for teaching not punishment • Limit TV, computer | <input type="checkbox"/> SAFETY <ul style="list-style-type: none"> • Sexual safety • Pedestrian safety • Safety helmets • Swimming safety • Fire escape plan • Smoke/carbon monoxide detectors • Guns • Sun • Appropriately restrained in all vehicles |
| <input type="checkbox"/> NUTRITION AND PHYSICAL ACTIVITY <ul style="list-style-type: none"> • Healthy weight • Well-balanced diet, including breakfast • Fruits, vegetables, whole grains, dairy | |

Additional comments or recommendations: _____

Signed: _____ Date: _____
Physician/APRN/PA/EPSTDT Provider

Address: _____ Telephone: _____