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 INDENTIFYING 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:** ____________

Vision			Hearing			
Vision	**Right 20/**________	**Passed** ☐	**Hearing – Right**	**Passed** ☐	**Failed** ☐	**Referred** ☐
	Left 20/________	**Failed** ☐ **Referred** ☐	**Hearing - Left**	**Passed** ☐	**Failed** ☐	**Referred** ☐

Optional: Hct/HGB: ______________ **Lead:** ______________ **Urinalysis:** ______________

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	☐ **Normal**	☐ **Abnormal** ________________	**Refer/Tx:** ______________
Scoliosis assessment	☐ **Normal**	☐ **Abnormal** ________________	**Refer/Tx:** ______________

(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**

☐ **MENTAL HEALTH**

- **Family time**
- **Anger management**
- **Discipline for teaching not punishment**
- **Limit TV, computer**

☐ **NUTRITION AND PHYSICAL ACTIVITY**

- **Healthy weight**
- **Well-balanced diet, including breakfast**
- **Fruits, vegetables, whole grains, dairy**
- **60 minutes of exercise/day**

☐ **ORAL HEALTH**

- **Regular dentist visits**
- **Brushing/Flossing**
- **Fluoride**

☐ **SAFETY**

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

Additional comments or recommendations: ____

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Signed:____________________________________ **Date:**____________________

Physician/APRN/PA/EPSDT Provider

Address:____________________________________ **Telephone:**____________________