



Marin County Report of Health Examination for School Entry

Child's Name _____ Birthdate _____ Grade _____ Medi-Cal # _____

Address _____ City _____ ZIP _____ Phone _____

Reason for referral if other than pre-K/1 physical: _____ School Nurse _____ Phone _____

HEALTH EXAMINATION MUST INCLUDE AREAS NOTED IN BOLD. (Please check if done and note results as appropriate)

Date of Exam: _____ Is child New? Established to your care? _____

Health and Developmental History

Nutritional Assessment

Physical Examination

Blood Test for Anemia

Urine Test

Height _____ Weight _____ B/P _____

Dental Assessment Normal Possible caries

Blood test for Lead: No Yes Result: _____

Exposure to second hand smoke? No Yes

Follow-Up / Referral
Please indicate who will follow-up
HEALTH PROVIDER | **SCHOOL NURSE**

DENTAL

Vision Testing: Acuity Test Used: Snellen Titmus

VISION

Right: 20/ _____ Left: 20/ _____

Eye muscle testing: Normal Abnormal

Referred? Yes No

Student should wear glasses: Yes No

Audiometry Screening

Tympanograms (Optional)

HEARING

	1000	2000	3000	4000
Right				
Left				

Right _____ Left _____

Referred? Yes No

Comments: _____

ADDITIONAL INFORMATION FROM HEALTH EXAMINER:

OTHER

Does this child have any conditions that might concern the school? No Yes

If yes, explain condition(s) and recommendations for follow-up: _____

Are there any restrictions from physical activities? No Yes

If yes, explain _____

Does this child take any medication(s)? No Yes If yes, explain _____

(If child must take medication at school, please request and complete an Authorization to Administer Medication form.)

Stamp or print examiner's name, address, phone number

Examiner's Signature

Immunization Dates

Polio (OPV or IPV)					
DTP / DTaP					
DT / Td					
HIB Meningitis					
MMR					
Hepatitis B					
Varicella					
Other					

TB skin test (PPD) required for school entry (Regardless of BCG)

TB Assessment completed, not at risk, deferred PPD (not an option for CHDP/ San Rafael students)

date given _____ Date read _____

duration _____ mm Negative Positive

Chest X-Ray required If positive

Date _____ Normal Abnormal

If any required immunizations were not given, list reason: _____

Exemption expiration date ____/____/____