



# 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-school 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? **Follow-Up / Referr:**  
Please indicate who will follow  
**HEALTH PROVIDER** **SCHOC NURS!**

**Health and Developmental History**

Nutritional Assessment

Height \_\_\_\_\_ Weight \_\_\_\_\_ B/P \_\_\_\_\_

Physical Examination

Dental Assessment |  Normal |  Possible caries **DENTAL**

Blood Test for Anemia

Blood Test for Lead:  No  Yes Result: \_\_\_\_\_

Urine Test

Exposure to second hand smoke?  No  Yes

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) **AUDIO**

	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 a medication form.)*

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



**Immunization Dates**

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

Examiner's Signature \_\_\_\_\_

**TB skin test (PPD) required for school entry unless BCG given within past 12 mos.**

Date given \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Date read \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Induration \_\_\_\_ mm  Negative  Positive

Chest X-Ray required If positive

Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_  Normal  Abnormal

If any required immunizations were not given, list reason: \_\_\_\_\_

Exemption expiration date \_\_\_\_ / \_\_\_\_ / \_\_\_\_