

**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: \_\_\_\_\_

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: \_\_\_\_\_

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: \_\_\_\_\_

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: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
 Physician/APRN/PA/EPSTDT Provider

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_