HEAD START REQUIREMENT FOR ENROLLMENT

FLORIDA DEPARTMENT OF HEALTH

STATE OF FLORIDA
School Entry Health Exam

To Parent/Guardian: Please complete and sign Part I — Child's Medical History.
State law for school entry requires a health examination by a legally qualified professional. Additional requirements may be determined by local school districts.

(Please Print)

Name of Child (Last, First, Middle)		Birth Date	Sex
Johnny Smith		10/29/2011	Male
Address (Street)		**School**	**Grade**
4350 E ELLICOTT STREET		Name of School	HeadStart
City and ZIP Code	**Home Telephone Number**	**Parent/Guardian (Last, First, Middle)**	
33610	813-740-7870	Smith, Megan	

PART I — CHILD'S MEDICAL HISTORY

To Parent/Guardian: Please check answers to questions 1 through 8 below in the column on the left.
(Please explain any "Yes" answers in the space provided below.)

PLEASE ANSWER QUESTIONS

1. Yes ☐ No ☒ Any concerns about general health (eating and sleeping habits, weight, etc.)?
2. Yes ☐ No ☒ Any other specific illness or social/emotional or behavioral problems?
3. Yes ☐ No ☒ Any allergies (food, insects, medication, etc.)?
4. Yes ☐ No ☒ Any prescription medication (daily or occasionally)?
5. Yes ☐ No ☒ Any problems with vision, hearing, or speech (glasses, contacts, ear tubes, hearing aids)?
6. Yes ☐ No ☒ Any hospitalization, operation, or major illness (specify problem)?
7. Yes ☐ No ☒ Any significant injury or accident (specify problem)?
8. Yes ☐ No ☒ Would you like to discuss anything about your child's health with a school nurse?

To Parent/Guardian: Please explain any "Yes" answers from above.

I am the parent/guardian of the child named above. I give permission for the information on PARTS I and II of this form provided about my child to be reviewed and utilized only by the staff of this school and any school health personnel providing school health services in the district for the limited purpose of meeting my child's health and educational needs.

☒ Megan Smith — **Signature of Parent/Guardian**

11/4/2014 — **Date**

Partnership for School Readiness Recommendations for Prekindergarten and Kindergarten

To Parent/Guardian: Please obtain the services listed below in order to find any problems. Please work with your health care provider to correct or treat any problems that may reduce your child's ability to learn in school. **(These services are recommended but not required.)**

1. Comprehensive Vision Examination (3-5 years of age) Date of Exam: _____ Results of Exam: _____ _____ Health Care Provider: _____ *(check one)* Optometrist ☐ Ophthalmologist ☐	Please describe any corrective action for any problems detected and any accommodations required.
2. Comprehensive Dental Examination Date of Exam: _____ Results of Exam: _____ _____ Dentist: _____	Please describe any corrective action for any problems detected and any accommodations required.
3. Hearing Screening Date of Exam: _____ Results of Exam: _____ _____ Health Care Provider: _____	Please describe any corrective action for any problems detected and any accommodations required.

HEAD START REQUIREMENT FOR ENROLLMENT

FLORIDA DEPARTMENT OF HEALTH

Name of Child (Last, First, Middle)	Birth Date
Smith, Johnny	10/29/2011

MUST BE COMPLETED

PART II — MEDICAL EVALUATION

To be completed and signed by the Health Care Provider ONLY:

The child named above has had a complete history and physical exam on the following date: 11 (Month) 4 (Day) 2014 (Year)

(Exam must be within one year of enrollment)

Exam Date

Screening Results:

Height: 39 Weight: 32 BMI%: ____ B/P: 120/80 Hct/Hgb: 12.0 Lead: <3.3 Urinalysis: ____

Vision - Without Glasses	Right 20/ 20	Left 20/ 20	Passed ☒ Failed ☐ Referred ☐	Hearing – Right	Passed ☒	Failed ☐	Referred ☐
Vision - With Glasses	Right 20/____	Left 20/____		Hearing – Left	Passed ☒	Failed ☐	Referred ☐

EXPIRES AFTER ONE YEAR

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: ____
Postural assessment	☐ Normal	☐ Abnormal	____	Refer/Tx: ____

TB risk assessment done ☐ ***(Please review Targeted Testing Guidelines listed below.)***

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.

(This form will be stored in the child's Cumulative Health Folder and may be accessed by both school and health personnel.)

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) ____

DATE ISSUED

Signature/Title of Health Care Provider	Date	Address (Please print or stamp)
☒	___/___/___	
Name (Please print or stamp)		

Tuberculosis Targeted Testing Guidelines for Health Care Providers

Tuberculosis Infection Risk:

Review the following risks and administer a Mantoux TB skin test if child is in one or more categories. The TB test is administered confidentially as part of the health examination. ***Do not record administration of any TB test or related information on this form.***

- Recent immigrant (< 5 years), frequent visitor to TB endemic areas
- Close contact to active TB case
- Frequent contact with adults at high-risk for disease, HIV+, homeless, incarcerated, illicit drug user
- HIV+ or have other medical conditions that increase the risk to progress from infection to disease, e.g., chronic renal failure, diabetes, hematologic or any other malignancy, weight loss > 10% of ideal body weight, on immunosuppressive medications

Active TB Disease Risk:

- Does the child exhibit signs/symptoms of tuberculosis (e.g. cough for three weeks or longer, weight loss, loss of appetite)?
- If symptoms are present, work-up or refer for TB disease evaluation.

FLORIDA DEPARTMENT OF HEALTH

FLORIDA CERTIFICATION OF IMMUNIZATION

Legal Authority: Sections 1003.22, 402.305, 402.313, Florida Statutes; rules 64D-3.046, 65C-20.011, Florida Administrative Code

LAST NAME	FIRST NAME	MI	DOB (MO/DA/YR)
PARENT OR GUARDIAN	CHILD'S SS# (optional)	STATE IMMUNIZATION ID# (optional)	

Directions:

- Enter all appropriate doses and dates below.
- Sign and date appropriate certificate (A, B, or C) on form.
- See "Immunization Guidelines Florida Schools, Child Care Facilities and Family Day Care Homes" for information and instructions on form completion. Guidelines are available at: http://us/disease_ctrl/immune/schoolguide.pdf.

VACCINE	DOE CODE	Dose 1 MO/DA/YR	Dose 2 MO/DA/YR	Dose 3 MO/DA/YR	Dose 4 MO/DA/YR	Dose 5 MO/DA/YR
DTaP/DTP	A					
DT	B					
Td/Tdap	C					
Polio	D					
Hib	E					
MMR (Combined)	F					
(Separate)	G, H,					
		Measles (dose 1)	*Measles (dose2)*	*Mumps (dose 1)*	*Mumps (dose 2)*	
	I					
		Rubella (dose 1)	*Rubella (dose 2)*			
Hepatitis B	J					
Varicella	K					
Varicella Disease	L					
		Year				
PneumoConju						

Select appropriate box(es)
Certificate of Immunization for K-12

☐ **Part A-Complete**

Part A (Immunizations are complete for school entry and attendance and meet requirements for kindergarten and/or 7th grade {and for grades kindergarten through 12.} I have reviewed the records available, and to the best of my knowledge, the above named child has adequately been immunized for school attendance as documented above.) DOE Code 1

Temporary Medical Exemption **Expiration date:** _____

☐ **Part B-Temporary**

Part B (For children in day care, family day care homes, preschool and kindergarten grades through 12 who are incomplete for immunization in Part A) **Invalid without expiration date**. DOE Code 2

Permanent Medical Exemption

☐ **Part C-Permanent**

Part C (For medically contraindicated immunizations, list each vaccine and state valid clinical reasoning or evidence for exemption.)
DOE Code 3 _____
I certify the physical condition of this child is such that immunization(s) as indicated in Part C above is medically contraindicated.

Physician or Clinic Name
_____
_____
_____

Physician or
Authorized Signature: _____
Issued By: _____
Date: _____