December 1999

PREVENTATIVE HEALTH CARE EXAMINATION FORM - INITIAL ENTRY [headstart - fourth (4) grade]

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. Local school boards may extend this time not to exceed two (2) months. The administration shall have an approved program of continuous health supervision which shall include evidence of having been screened for vision and hearing.

PLEASE COMPLETE THE IDENTIFYING INFORMATION AND RECORDS

IDENTIFYING INFORMATION

Student Name: _____

Social Security Number: _____ **Date of Birth:** _____

Parent or Guardian Name: _____

RECORD OF IMMUNIZATIONS TO BE REPORTED ON IMMUNIZATION CERTIFICATE FORM, EPID 230.

MEDICAL HISTORY

Seizures: _____

Chronic Illness: _____

Allergies: _____

Medications: _____

Significant Historical Information: _____

_____

Physical Exam:

N.	Abn.	
_____	_____	General Appearance
_____	_____	HEENT
_____	_____	Skin
_____	_____	Neck
_____	_____	Chest
_____	_____	Heart
_____	_____	Abd - Genitalia
_____	_____	Extremities-Back
_____	_____	Neuro

Hgt:_____ **Wgt:**_____ **BP:**_____/_____
Hearing: R_____ L_____
Vision: R_____/_____ L_____/_____
STRABISMUS/AMBLYOPIA SCREEN ☐ **ABNORMAL**
Optional---------HCT/HGB: _____ **(required for headstart)**
Optional----------UA: _____

Explain Abnormal Exam: _____

_____

Recommendations:

_____ **No Restrictions: Normal Exam**

_____ **RESTRICTIONS AND SUGGESTIONS TO SCHOOL:** _____

_____

_____

Age appropriate and suggested anticipatory guidance *(health assessments)*

- ☐ **Discuss injury prevention with parents**
  - ☐ **Bicycle Safety** ☐ **Car Seat Belts** ☐ **Memorization of Name, Address and Phone Number**
- ☐ **Advise the child not to go with or accept anything from strangers and feel free to say "NO" to strangers.**
- ☐ **Emphasize the importance of dental care.**
- ☐ **Discuss mental health issues.**

Singed: _____ **Date:** _____
Physician/ARNP/PA/EPSDT Provider

Address: _____ **Telephone:** _____