

# San Francisco Unified School District - School Health Form

Completed by Parent or Caregiver: \_\_\_\_\_ Birthdate: \_\_\_\_\_ month/day/year \_\_\_\_\_  Male  Female School: \_\_\_\_\_  
 Child's Name: \_\_\_\_\_ Last, First \_\_\_\_\_ Phone: \_\_\_\_\_ Home \_\_\_\_\_ / Cell \_\_\_\_\_ / Work \_\_\_\_\_ Grade: \_\_\_\_\_

Address: \_\_\_\_\_ Street \_\_\_\_\_ Zip \_\_\_\_\_  
 Release of Health Information: I give permission to share the results of this examination with the School \_\_\_\_\_  
 Signature of Parent/Caregiver \_\_\_\_\_ Date \_\_\_\_\_

NOTE: Kindergarten entrance physical examination to be done no earlier than March of the year the child enters Kindergarten

Completed by health provider:

## IMMUNIZATION RECORD (EACH child should have a completed or updated official/ yellow Immunization Record)

Vaccine	Dose given Month / Day / Year					Tuberculin Skin Test (Mantoux/PPD) Date: _____
	1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>	4 <sup>th</sup>	5 <sup>th</sup>	
Polio:						Induration: _____ mm Impression: <input type="checkbox"/> Negative <input type="checkbox"/> Positive
DPT/DaP (Diphtheria, Pertussis, Tetanus)						Chest X-Ray/RX: required with Positive TB Skin Test
Td/DI (Tetanus, Diphtheria)						CXR Date: _____ Impression: <input type="checkbox"/> Negative <input type="checkbox"/> Positive
Hib (Haemophilus influenza type B)						RX treatment & duration: _____
MMR (Measles, Mumps, Rubella)						<input type="checkbox"/> Child has no risk factors for TB and does not require TB test *see back for risk factors
Hepatitis B						Health Provider Signature _____
(Specify if 2 dose formulation)						
Varicella (Chickenpox)						<input type="checkbox"/> Had Varicella disease - Approximate date _____

## HEALTH EXAMINATION - Date of Exam \_\_\_\_\_

	Results:	Relevant findings:	Follow-up/Referral Needed :
Health/Developmental History			
Physical Examination	Wt: _____ BP: _____ % ile Ht: _____ BMI: _____		
Dental Assessment			
Developmental Evaluation			
Vision Screening	R: 20/ _____ L: 20/ _____		
Audiometric (hearing) Screening	Right: _____ 1000 _____ 2000 _____ 4000 _____ Left: _____		
Nutritional Assessment			
Lab Tests	Urine _____ Lead _____ Blood test for anemia _____		
Other			

(If you do not want your child to have an exam, you may sign the waiver form, PM 171B, obtained from your child's school) See other side for more details.

- Examination revealed no condition relevant to the school program, e.g. allergies, asthma, cardiac condition, diabetes, epilepsy, etc.
- Medical condition identified - emergency care plan attached (emergency care plan template can be downloaded at [http://portal.sfusd.edu/template/default.cfm?page=chief\\_dev.health.MedicalForms](http://portal.sfusd.edu/template/default.cfm?page=chief_dev.health.MedicalForms))
- Medication taken at school - Name of medication: \_\_\_\_\_ Medication taken at home - Name of medication: \_\_\_\_\_
- (If medication is taken at school, complete a medication form for each medication (medication form template can be downloaded at [http://portal.sfusd.edu/template/default.cfm?page=chief\\_dev.health.MedicalForms](http://portal.sfusd.edu/template/default.cfm?page=chief_dev.health.MedicalForms))
- Restriction from physical activity - please specify \_\_\_\_\_

Name of Health Provider: \_\_\_\_\_ Child under my care since \_\_\_\_\_ Date: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Signature of Health Provider: \_\_\_\_\_