

## REPORT OF HEALTH EXAMINATION FOR SCHOOL ENTRY

To protect the health of children, California law requires a health examination on school entry. Please have this report filled out by a health examiner and return it to the school. The school will keep and maintain it as confidential information.

|  |       |          |                           |
|--|-------|----------|---------------------------|
| <b>PART I TO BE FILLED OUT BY A PARENT OR GUARDIAN</b> |       |          |                           |
| CHILD'S NAME—Last                                      | First | Middle   | BIRTH DATE—Month/Day/Year |
| ADDRESS—Number, Street                                 | City  | ZIP code | SCHOOL                    |

**PART II TO BE FILLED OUT BY HEALTH EXAMINER**

**HEALTH EXAMINATION**  
**NOTE: All tests and evaluations except the blood lead test must be done after the child is 4 years and 3 months of age.**

| REQUIRED TESTS/EVALUATIONS                | DATE (mm/dd/yy) |
|---|-----------------|
| Health History                            | / /             |
| Physical Examination                      | / /             |
| Dental Assessment                         | / /             |
| Nutritional Assessment                    | / /             |
| Developmental Assessment                  | / /             |
| Vision Screening                          | / /             |
| Audiometric (hearing) Screening           | / /             |
| TB Risk Assessment and Test, if indicated | / /             |
| Blood Test (for anemia)                   | / /             |
| Urine Test                                | / /             |
| Blood Lead Test                           | / /             |
| Other                                     | / /             |

**IMMUNIZATION RECORD**  
**Note to Examiner:** Please give the family a completed or updated yellow California Immunization Record.  
**Note to School:** Please record immunization dates on the blue California School Immunization Record (PM 286).

| VACCINE   | DATE EACH DOSE WAS GIVEN |        |       |        |       |
|---|--------------------------|--------|-------|--------|-------|
|   | First                    | Second | Third | Fourth | Fifth |
| <b>POLIO</b> (OPV or IPV)   |                          |        |       |        |       |
| <b>DtaP/DTP/DT/Td</b> (diphtheria, tetanus, and [acellular] pertussis) OR (tetanus and diphtheria only) |                          |        |       |        |       |
| <b>MMR</b> (measles, mumps, and rubella)  |                          |        |       |        |       |
| <b>HIB MENINGITIS</b> (Haemophilus Influenzae B)<br>(Required for child care/preschool only)            |                          |        |       |        |       |
| <b>HEPATITIS B</b>  |                          |        |       |        |       |
| <b>VARICELLA</b> (Chickenpox)   |                          |        |       |        |       |
| OTHER (e.g., TB Test, if indicated)   |                          |        |       |        |       |
| OTHER   |                          |        |       |        |       |

**PART III ADDITIONAL INFORMATION FROM HEALTH EXAMINER (optional) and RELEASE OF HEALTH INFORMATION BY PARENT OR GUARDIAN**

**RESULTS AND RECOMMENDATIONS**  
 Fill out if patient or guardian has signed the release of health information.

Examination shows no condition of concern to school program activities.

Conditions found in the examination or after further evaluation that are of importance to schooling or physical activity are: *(please explain)*

I give permission for the health examiner to share the additional information about the health check-up with the school as explained in Part III.

Please check this box if you **do not** want the health examiner to fill out Part III.

\_\_\_\_\_  
Signature of parent or guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name, address, and telephone number of health examiner

\_\_\_\_\_  
Signature of health examiner

\_\_\_\_\_  
Date

**If your child is unable to get the school health check-up, call the Child Health and Disability Prevention (CHDP) Program in your local health department. If you do not want your child to have a health check-up, you may sign the waiver form (PM 171 B) found at your child's school.**