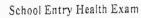


STATE OF FLORIDA School Entry Health Exam

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.

Birth Date	Sex
School	Grade
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Please describe any correany accommodations req	rgarten work with your health care provider to are recommended but not required.) ective action for any problems detected uired. ctive action for any problems detected uired.
	Parent/Guardian (Last D'S MEDICAL HISTORY ugh 8 below in the column on ing and sleeping habits, weig tional or behavioral problem in, etc.)? recasionally)? recech (glasses, contacts, ear r illness (specify problem)? ify problem)? ut your child's health with a bove.





Page 2 of 2 Rieth Date Name of Child (Last, First, Middle) 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: Year (Exam must be within one year of enrollment) Month Screening Results: Urinalysis: Hct/Hgb: Lead: BMI%: Height: Weight: Referred Failed _ Passed Hearing - Right Passed Left 20/ Right 20/ Vision - Without Glasses Failed Referred [Failed Hearing - Left Passed Left 20/ Right 20/ Vision - With Glasses Referred Refer/Tx: ☐ Normal Abnormal Gross dental (teeth and gums) Refer/Tx: Abnormal Normal Head/scalp/skin Refer/Tx: Abnormal Eyes/Ears/Nose/Throat Normal Refer/Tx: Abnormal Normal Chest/Lungs/Heart Refer/Tx: Abnormal Normal Abdomen Refer/Tx: Normal Abnormal Postural assessment (Please review Targeted Testing Guidelines listed below.) TB risk assessment done This child has the following problems that may impact the educational experience: Social/Behavioral Cognitive Speech/Language Physical Hearing Vision 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) Address (Please print or stamp) Signature/Title of Health Care Provider 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.