

San Francisco Unified School District - School Health Form

Completed by Parent or Caregiver: _____

Child's Name: _____

Birthdate: _____

Male Female

School: _____

Last, First _____

month/day/year _____

Address: _____

Street _____ Zip _____

Phone: _____

Home _____

Cell _____

Work _____

Grade: _____

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

HEALTH EXAMINATION - Date of Exam _____

Health/Developmental History	Results:	Relevant findings:	Follow-up/Referral Needed :
Physical Examination	Wt: _____ BP: _____ Ht: _____ BMI: _____ %ile _____		
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)
- 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)
- Restriction from physical activity - please specify _____

Name of Health Provider: _____ Child under my care since _____

Address: _____ Signature of Health Provider: _____ Date: _____

Phone: _____