



STATE OF FLORIDA  
School Entry Health Exam

Page 1 of 2

**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.

*(Please Print)*

Name of Child (Last, First, Middle)		Birth Date	Sex
Address (Street)		School	Grade
City and ZIP Code	Home Telephone Number	Parent/Guardian (Last, First, Middle)	

**PART I — CHILD'S MEDICAL HISTORY**

**To Parent/Guardian:** Please check answers to questions 1 through 8 below in the column on the left.

*(Please explain any "Yes" answers in the space provided below.)*

- |                                 |                             |  |
|---------------------------------|-----------------------------|--|
| 1. Yes <input type="checkbox"/> | No <input type="checkbox"/> | Any concerns about general health (eating and sleeping habits, weight, etc.)?              |
| 2. Yes <input type="checkbox"/> | No <input type="checkbox"/> | Any other specific illness or social/emotional or behavioral problems?                     |
| 3. Yes <input type="checkbox"/> | No <input type="checkbox"/> | Any allergies (food, insects, medication, etc.)?   |
| 4. Yes <input type="checkbox"/> | No <input type="checkbox"/> | Any prescription medication (daily or occasionally)?                                       |
| 5. Yes <input type="checkbox"/> | No <input type="checkbox"/> | Any problems with vision, hearing, or speech (glasses, contacts, ear tubes, hearing aids)? |
| 6. Yes <input type="checkbox"/> | No <input type="checkbox"/> | Any hospitalization, operation, or major illness (specify problem)?                        |
| 7. Yes <input type="checkbox"/> | No <input type="checkbox"/> | Any significant injury or accident (specify problem)?                                      |
| 8. Yes <input type="checkbox"/> | No <input type="checkbox"/> | Would you like to discuss anything about your child's health with a school nurse?          |

**To Parent/Guardian:** Please explain any "Yes" answers from above.

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I am the parent/guardian of the child named above. I give permission for the information on PARTS I and II of this form provided about my child to be reviewed and utilized only by the staff of this school and any school health personnel providing school health services in the district for the limited purpose of meeting my child's health and educational needs.

DD

Signature of Parent/Guardian

Date

**Partnership for School Readiness Recommendations for Prekindergarten and Kindergarten**

**To Parent/Guardian:** Please obtain the services listed below in order to find any problems. Please work with your health care provider to correct or treat any problems that may reduce your child's ability to learn in school. (These services are recommended but not required.)

1. Comprehensive Vision Examination (3-5 years of age) Date of Exam: _____ Results of Exam: _____  Health Care Provider: _____ (check one) Optometrist <input type="checkbox"/> Ophthalmologist <input type="checkbox"/>	Please describe any corrective action for any problems detected and any accommodations required.
2. Comprehensive Dental Examination Date of Exam: _____ Results of Exam: _____  Dentist: _____	Please describe any corrective action for any problems detected and any accommodations required.
3. Hearing Screening Date of Exam: _____ Results of Exam: _____  Health Care Provider: _____	Please describe any corrective action for any problems detected and any accommodations required.

# Physical Exam For School In Browarf County

**Marco Cascella**



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