

# SCHOOL MEDICAL EXAMINATION FORM - Sixth (6) Grade Form

All local boards of education shall require a medical examinations of each child first entering school within a period of six months prior to or one month following admission to school and a second examination shall be required within six months prior to entry into the sixth grade. Each board shall have an approved program of continuous health supervision which shall include evidence of having been screened for tuberculosis in accordance with KRS 158.036 and 214.034, vision, hearing, and scoliosis scheduled screening tests.

## PLEASE COMPLETE THE IDENTIFYING INFORMATION AND RECORDS

### IDENTIFYING INFORMATION

Student Name: \_\_\_\_\_ Birthday: \_\_\_\_\_  
 Parent or Guardian Name: \_\_\_\_\_  
 Address: \_\_\_\_\_ Telephone: \_\_\_\_\_  
 In Emergency Call: \_\_\_\_\_ Telephone: \_\_\_\_\_  
 Student's Physician: \_\_\_\_\_ Student's Dentist: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Phone: \_\_\_\_\_

### RECORD OF IMMUNIZATIONS TO BE REPORTED ON IMMUNIZATION CERTIFICATE FORM, EPID.230.

### MEDICAL HISTORY

Seizures: \_\_\_\_\_  
 Chronic Illness: \_\_\_\_\_  
 Allergies: \_\_\_\_\_  
 Medications: \_\_\_\_\_  
 Significant Historical Information: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### Physical Exam:

N.	Abn.	
_____	_____	General Appearance
_____	_____	HEENT
_____	_____	Neck
_____	_____	Chest
_____	_____	Heart
_____	_____	Abd-Genitalia
_____	_____	Extremities-Back
_____	_____	Neuro

Hgt: \_\_\_\_\_ Wgt: \_\_\_\_\_ BP: \_\_\_\_\_ / \_\_\_\_\_  
 Hearing: R \_\_\_\_\_ L \_\_\_\_\_  
 Vision: R \_\_\_\_\_ / \_\_\_\_\_ L \_\_\_\_\_ / \_\_\_\_\_

School Readiness - Normal: \_\_\_\_\_  
 Needs Evaluation: \_\_\_\_\_  
 HCT: \_\_\_\_\_  
 Optional \_\_\_\_\_ UA: \_\_\_\_\_  
 T.B. Testing: Date Given \_\_\_\_\_  
 Read \_\_\_\_\_  
 Type \_\_\_\_\_ Induration \_\_\_\_\_

Explain Abnormal Exam: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### Recommendations:

\_\_\_\_\_ No Restrictions: Normal Exam  
 \_\_\_\_\_ No Restrictions - Abnormal Exam - Explain: \_\_\_\_\_  
 \_\_\_\_\_

Special Seating Needed: YES \_\_\_\_\_ NO \_\_\_\_\_

Restrictions and suggestions to school: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Signature: \_\_\_\_\_  
 Physician/Advanced Registered Nurse Practitioner/EPST Provider

Date: \_\_\_\_\_



# IMMUNIZATION CERTIFICATE

(Required of each child enrolled in a licensed Day Care Center, Kindergarten, Public or Private School.)

Name of Student \_\_\_\_\_ Birthdate \_\_\_\_\_  
(Last) (First) (Middle)

Name of Parent or Guardian \_\_\_\_\_

Address \_\_\_\_\_  
(Street) (City) (State) (Zip Code)

DIPHTHERIA, TETANUS AND PERTUSSIS VACCINES<sup>a, b</sup> DATES ADMINISTERED (month/day/year)  
#1 / / #2 / / #3 / / #4 / / #5 / /

ORAL POLIO VACCINE<sup>b</sup> #1 / / #2 / / #3 / / #4 / /

MMR (Measles, Mumps<sup>c</sup>, Rubella) #1 / / #2 / / \_\_\_\_\_  
Other (Specify) \_\_\_\_\_

Hib (Haemophilus b)<sup>c</sup> #1 / / #2 / / #3 / / #4 / / \_\_\_\_\_  
Other (Specify) \_\_\_\_\_

Hepatitis B<sup>c</sup> #1 / / #2 / / #3 / / #4 / /

<sup>a</sup>DTP, DT and/or Td. <sup>b</sup>Dependent upon age at which immunizations were begun. <sup>c</sup>Mumps, Hib, and Hepatitis B are not required for school entry.  
This child is current for immunizations until / / , after which this certificate is no longer valid and a new certificate must be obtained. I CERTIFY THAT THE ABOVE NAMED CHILD HAS RECEIVED IMMUNIZATIONS AS STIPULATED ABOVE.

Signature of Physician or Health Dept. \_\_\_\_\_ (Date) \_\_\_\_\_

This Certificate should be presented to the school in which the child intends to enroll and should be retained by the school and filed with the child's school health record.