

PREVENTATIVE HEALTH CARE EXAMINATION FORM - INITIAL ENTRY [headstart - fourth (4) grade]

All local boards of education shall require a preventative health care examination of each child first entering a Kentucky public school within a period of twelve (12) months prior to initial admission to school. Local school boards may extend this time not to exceed two (2) months. The administration shall have an approved program of continuous health supervision which shall include evidence of having been screened for vision and hearing.

PLEASE COMPLETE THE IDENTIFYING INFORMATION AND RECORDS

IDENTIFYING INFORMATION

Student Name: _____

Social Security Number: _____ Date of Birth: _____

Parent or Guardian Name: _____

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
_____	_____	Skin
_____	_____	Neck
_____	_____	Chest
_____	_____	Heart
_____	_____	Abd - Genitalia
_____	_____	Extremities-Back
_____	_____	Neuro.

Hgt: _____ Wgt: _____ BP: _____ / _____
Hearing: R _____ L _____
Vision: R _____ / _____ L _____ / _____
STRABISMUS/AMBLYOPIA SCREEN ABNORMAL
Optional-----HCT/HGB: _____ (required for headstart)
Optional-----UA: _____

Explain Abnormal Exam: _____

Recommendations:

_____ No Restrictions: Normal Exam

_____ RESTRICTIONS AND SUGGESTIONS TO SCHOOL: _____

Age appropriate and suggested anticipatory guidance (health assessments)

- Discuss injury prevention with parents
 - Bicycle Safety
 - Car Seat Belts
 - Memorization of Name, Address and Phone Number
- Advise the child not to go with or accept anything from strangers and feel free to say "NO" to strangers.
- Emphasize the importance of dental care.
- Discuss mental health issues.

Signed: _____ Date: _____

Physician/ARNP/PA/EPST Provider

Address: _____ Telephone: _____



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^{a, b} DATES ADMINISTERED (month/day/year)
#1 / / #2 / / #3 / / #4 / / #5 / /

ORAL POLIO VACCINE^b #1 / / #2 / / #3 / / #4 / /

MMR (Measles, Mumps^c, Rubella) #1 / / #2 / / _____
Other (Specify) _____

Hib (Haemophilus b)^c #1 / / #2 / / #3 / / #4 / / _____
Other (Specify) _____

Hepatitis B^c #1 / / #2 / / #3 / / #4 / /

^aDTP, DT and/or Td. ^bDependent upon age at which immunizations were begun. ^cMumps, 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.

**Archdiocese of Louisville
Kentucky Eye Examination Form for School Entry**

Effective with the 2004-05 school year, Archdiocese of Louisville Catholic elementary schools require proof of a vision examination by an optometrist or ophthalmologist be submitted to the school no later than January 1 of the first year that a three (3), four (4), five (5), or six (6) year old child is enrolled. Vision examination information may be reported on the Kentucky/Archdiocese of Louisville Eye Examination Form for School Entry.

PLEASE COMPLETE THE IDENTIFYING INFORMATION AND RECORDS

IDENTIFYING INFORMATION

Student Name:	
Date of Birth:	
Parent or Guardian Name:	

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

CASE HISTORY

Date of Exam: _____

Ocular History: Normal or Positive for: _____

Medical History: Normal or Positive for: _____

Drug Allergies: NKDA or Allergic to: _____

Family Ocular and Medical History: Amblyopia Strabismus Glaucoma Diabetes

Other: _____

Other Pertinent Information: _____

Refraction with cycloplegic? (please indicate one) YES NO

	<u>OD</u>	<u>OS</u>
Unaided Acuity	20 / _____	20 / _____
Best Corrected Acuity	20 / _____	20 / _____

	Normal	Abnormal	Not able to assess
External Exam (eye and adnexa)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Internal Exam (media, lens, fundus, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurological Integrity (pupils)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Binocular Function (stereopsis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Accommodation and convergence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Color Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Diagnosis: Normal Myopia Hyperopia Astigmatism Strabismus Amblyopia

Other: _____

Recommendations:

1 Glasses prescribed: Yes No

2. _____

3. _____

Age appropriate and suggested anticipatory guidance (health assessments):

- Educate (parents/patients) about eye/vision disorders and needed vision care
- Counsel (parents/patients) regarding eye safety
- Stress importance of early, preventative eye care
- Recommend re-examination, as appropriate

Signed: _____
Optometrist/Ophthalmologist

Date: _____

Address: _____

Phone: () _____