School Health Form

Completed by Parent of Caregiver:

Child's Name: _____ Birthdate: _____ ☐ Male ☐ Female School: _____
Last, First month/day/year

Address: _____ Phone: _____ / _____ / _____ Grade: _____
Street Zip Home Cell Work

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**)

	Dose given Month / Day / Year					Tuberculin Skin Test (Mantoux/PPD)*
Vaccine	1st	2nd	3rd	4th	5th	Date:
Polio:						Induration:_____mm Impression: ☐ Negative ☐ Positive
DPT/DTap (Diphtheria, Pertussis, Tetanus)						Chest X-Ray/RX: required with Positive TB Skin Test
Td/DT (Tetanus, Diphtheria)						CXR Date: _____ Impression: ☐ Negative ☐ Positive
Hib (Haemophilus influenza type B)						RX treatment & duration:
MMR (Measles, Mumps, Rubella)			Not to be given before the 1st birthday			**Required by The Archdiocese of San Francisco*
Hepatitis B (Specify if 2 dose formulation)						
Varicella (Chickenpox)						

HEALTH EXAMINATION – Date of Exam _____

	Results:					Relevant findings:	Follow-up/Referral Needed:
Health/Development History							
Physical Examination	Wt: _____ BP: _____ Ht: _____ BMI: _____%ile						
Dental Assessment							
Developmental Evaluation							
Vision Screening	R: 20/_____ L: 20/ _____						
Audiometric (hearing) Screening			1000	2000	4000		
	Right:						
	Left:						
Nutritional Assessment							
Lab Test	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.
☐ Medication taken at school – Name of medication: _____ Medication taken at home – Name of medication: _____
(If medication is take at school, complete a medication form for each medication)
☐ Restriction from physical activity – please specify _____

Name of Health Provider: Child under my care since _____.
Address:
Phone: Signature of Health Provider: Date: