PREVENTATIVE HEALTH CARE EXAMINATION FORM

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 and within one (1) year prior to entry to sixth grade. Local school boards may extend this time not to exceed two (2) months. (702 KAR 1:160)

PLEASE COMPLETE THE INDENTIFYING INFORMATION AND RECORDS

IDENTIFYING INFORMATION

Student Name: _____ **Gender: M F Grade:** _____

Date of Birth: _____ **Age:** _____ **yrs** _____ **months Preferred Language:** _____

Parent or Guardian Name: _____

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

MEDICAL HISTORY

Allergies: _____

Current Prescribed Medications to be taken daily at school: _____

Significant Historical Information: _____

SCREENING RESULTS:

Height: _____ **ft** _____ **inches** _____ **Weight** _____ **BMI:** _____ **BMI%** _____ **B/P:** _____

Vision	**Right 20/_____**	**Passed** ☐ **Failed** ☐ **Referred** ☐	**Hearing – Right**	**Passed** ☐	**Failed** ☐	**Referred** ☐
	Left 20/_____		**Hearing - Left**	**Passed** ☐	**Failed** ☐	**Referred** ☐

Optional: Hct/HGB: _____ **Lead:** _____ **Urinalysis:** _____

Gross dental (teeth and gums)	☐ **Normal**	☐ **Abnormal** _____	**Refer/Tx:** _____
Head/scalp/skin	☐ **Normal**	☐ **Abnormal** _____	**Refer/Tx:** _____
Eyes/Ears/Nose/Throat	☐ **Normal**	☐ **Abnormal** _____	**Refer/Tx:** _____
Chest/Lungs/Heart	☐ **Normal**	☐ **Abnormal** _____	**Refer/Tx:** _____
Abdomen	☐ **Normal**	☐ **Abnormal** _____	**Refer/Tx:** _____
Scoliosis assessment	☐ **Normal**	☐ **Abnormal** _____	**Refer/Tx:** _____

(Over)

This child has the following problems that may impact the educational experience:

☐ **Vision** ☐ **Hearing** ☐ **Speech/Language** ☐ **Physical** ☐ **Social/Behavioral** ☐ **Cognitive**

Specify: _____

_____

☐ **This child has a health condition that may require emergency action at school, e.g. seizures, allergies. Specify below.**

_____

Recommendations (Attach additional sheet if necessary): _____

_____

(Please Check One)

☐ **This child may participate fully in school activities including physical education.**

☐ **This child may participate in school activities including physical education with the following restriction/adaptation.**

(Specify reason and restriction) _____

_____

ANTICIPATORY GUIDELINES

Discussed and/or handout given

☐ **SCHOOL READINESS**
- **Establish routines**
- **After-school care/activities**
- **Friends**
- **Bullying**
- **Communicate with teachers**

☐ **MENTAL HEALTH**
- **Family time**
- **Anger management**
- **Discipline for teaching not punishment**
- **Limit TV, computer**

☐ **NUTRITION AND PHYSICAL ACTIVITY**
- **Healthy weight**
- **Well-balanced diet, including breakfast**
- **Fruits, vegetables, whole grains, dairy**
- **60 minutes of exercise/day**

☐ **ORAL HEALTH**
- **Regular dentist visits**
- **Brushing/Flossing**
- **Fluoride**

☐ **SAFETY**
- **Sexual safety**
- **Pedestrian safety**
- **Safety helmets**
- **Swimming safety**
- **Fire escape plan**
- **Smoke/carbon monoxide detectors**
- **Guns**
- **Sun**
- **Appropriately restrained in all vehicles**

Additional comments or recommendations: _____

_____

_____

_____

_____

_____

Signed: _____ **Date:** _____

Physician/APRN/PA/EPSDT Provider

Address: _____ **Telephone:** _____

Permission Form for Prescribed Medication

TO BE COMPLETED BY SCHOOL PERSONNEL

School: Heritage Christian Academy (HCA) School Year:_____ Date form received:_____

I/we acknowledge receipt of this Physician's Statement and Parent Authorization._____

Student Name:_____ Student age:_____ Date of Birth:_____

Grade:_____ Homeroom/Classroom:_____

TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED PROVIDER

Name of medication:_____

Reason for medication:_____

Form of medication/treatment:

☐ Tablet/capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Nebulizer ☐ Other _____

Instructions (Schedule and dose to be given at school):_____

_____

Start: ☐ Date form received ☐ Other, as specified:_____

Stop: ☐ End of school year ☐ Other date/duration:_____

☐ **For episodic/emergency events only**

Restrictions and/or important side effects: ☐ No restrictions

☐ Yes. Please describe:_____

_____

Special storage requirements: ☐ None ☐ Refrigerate

Other:_____

Physician's Signature_____ Physician's Name:_____

Date_____ Phone_____ Address:_____

♦♦♦**For Self-Administration ONLY**♦♦♦**For Self-Administration ONLY**♦♦♦**For Self-Administration ONLY**♦♦♦**For Self-Administration ONLY**♦♦♦

Pursuant to KRS 158.832 to KRS 158.836 _____ school permits a student to possess and self-administer asthma or anaphylaxis medication at school and at school-related functions upon completion of the following information by the parent/ guardian and the student's physician and waiver of liability by the parent/guardian.

This student has been **instructed** on self-administration of this medication: **to be completed for asthmatic, diabetic or severe allergic reaction (anaphylaxis) ONLY**

☐ No ☐ Supervision required ☐ Supervision not required

This student may carry this medication: ☐ No ☐ Yes

Please indicate if you have provided additional information:

☐ On the back side of this form ☐ As an attachment

Signature:_____ Date_____

Physician or Authorized Provider

TO BE COMPLETED BY PARENT / GUARDIAN

I give permission for (name of child)_____ is to receive the above stated medication at school according to standard school policy. I release the HCA School Board and its employees from any claims or liability connected with its reliance on this permission. (Parent/guardians to bring the medication in its original container.)

Date:_____ **Signature:**_____ **Relationship:**_____

Home phone:_____ **Work phone:**_____ **Emergency phone:**_____

Modeled after the American Academy of Pediatrics

KDE/DSS **Kentucky Eye Examination Form for School Entry** **KDESHS004**

KRS 156.160 (1) (g) requires proof of a vision examination by an optometrist or ophthalmologist. This evidence shall 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 in public school, public preschool, or Head Start program.

PLEASE COMPLETE THE IDENTIFYING INFORMATION

Date of student's enrollment: _____ **Date of Vision Examination: _____**

IDENTIFYING INFORMATION

Student Name: _____

Date of Birth: _____

Parent or Guardian Name: _____

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

	OD	OS
Unaided Acuity	20/	20/
Best Corrected Acuity	20/	20/

Type of Examination	Normal	Abnormal	Notable to Assess
External Exam (eye and adnexa)			
Internal Exam (media, lens, fundus, etc)			
Neurological Integrity (pupils)			
Binocular Function (stereopsis)			
Accommodation and convergence			
Color Vision			

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: _____ Date: _____
Optometrist/Ophthalmologist

Address: _____ Telephone: ( ) _____

OAS/DSS **Kentucky Dental Screening/Examination Form for School Entry** **KDESHS005**

Kentucky law, KRS 156.160(i), requires proof of a dental screening or examination by a dentist, dental hygienist, physician, registered nurse, advanced registered nurse practitioner, or physician assistant. This evidence shall be presented to the school no later than January 1 of the first year that a five (5) or six (6) year old is enrolled in public school.

Student Name: _____
Last First Middle

Birth date: _____/_____/_____ Gender: ☐ 0 Male ☐ 1 Female

Parent or Guardian:_____
Name Relationship

Address:_____ City: _____

Phone Number:_____ School:_____

Date of Exam/Screening _____/_____/_____

Test Type (check one)

☐ Screening

☐ Exam

Screener's Name: _____

Screener's Address: _____

_____

Phone Number:_____Screening Date:_____

Screener's Signature:_____

Professional affiliation: (Please check one)

☐ Dentist ☐ Dental Hygienist

☐ Physician Assistant ☐ Registered Nurse with training

☐ APRN ☐ Physician

Untreated Decay: (Check one)

☐ 0 No untreated cavities

☐ 1 Untreated cavities

Treated Decay: (Check one)

☐ 0 No treated cavities

☐ 1 Treated cavities

Pattern of Early Childhood Cavities: (Check one)

☐ 0 No Early Childhood Cavities

☐ 1 Early Childhood Cavities Present

Treatment Urgency: (Check one)

☐ 0 No obvious problem

☐ 1 Early dental care needed

☐ 2 Referral for Urgent Care
NOTE: Comment required if marked.

Comments: