San Francisco Unified School District School Health Form

COMPLETED BY HEALTH PROVIDER

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Dose Given:</th>
<th>Child has no risk factors for TB and does not require TB test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Polio (IPV)</td>
<td>1st</td>
<td>☐</td>
</tr>
<tr>
<td>DTaP (Diphtheria, Tetanus, Pertussis)</td>
<td>2nd</td>
<td>☐</td>
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<tr>
<td>Td/Tdap (Tetanus, Diphtheria, Pertussis)</td>
<td>3rd</td>
<td>☐</td>
</tr>
<tr>
<td>MMR</td>
<td>4th</td>
<td>☐</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>5th</td>
<td>☐</td>
</tr>
<tr>
<td>Hepatitis A (not required)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicella</td>
<td></td>
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</tbody>
</table>

IMMUNIZATION RECORD (EACH child should have a completed or updated official Immunization Record)

- Polio (IPV)
- DTaP (Diphtheria, Tetanus, Pertussis)
- Td/Tdap (Tetanus, Diphtheria, Pertussis)
- MMR
- Hepatitis B
- Hepatitis A (not required)
- Varicella

Dose Given: Month / Day / Year

Health Provider Signature: ______________________

SUMMARY OF FINDINGS/CONDITIONS

- Weight: ______ Height: ______ BMI %ile: ______ B/P: ______ Lead: ______ Hgb/Hct: ______ U/A: ______

Vision/Hearing

- Near Vision: R: 20/____ L: 20/____ Both: 20/____
- Color Vision (2nd grade boys): ☐ Pass ☐ Fail

- Distance Vision: R: 20/____ L: 20/____ Both: 20/____
- Hearing: R: ☐ Pass ☐ Fail L: ☐ Pass ☐ Fail
- Has glasses

Physical Examination

- ☐ Medical condition(s) identified *Specify:
- ☐ Medication taken at school: ** Specify:
- ☐ At home:
- ☐ Restrictions from school activities Specify:

*Emergency Care Plan(s) required for condition needing potential action at school. **Medication form required for each med.

Forms can be found in the SFUSD School Health Manual: [http://www.healthiersf.org/resources/SIM.php](http://www.healthiersf.org/resources/SIM.php)

Dental Assessment

- ☐ NO dental problems
- ☐ Dental problems Specify:

Developmental Assessment

- ☐ Development is within age expectations
- ☐ Developmental concern(s) Specify:
- ☐ Developmental diagnosis Specify:

Nutritional Assessment

OTHER

Signature/Title of Health Provider: ______________________

Date / / Address/Phone (Print/Stamp):

Name (Please print or stamp):

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