

San Francisco Unified School District School Health Form

يستكمل بواسطة ولي الامر او مقدم الرعاية:

اسم الطفل: _____ اللقب _____ الاول _____
 تاريخ الميلاد: _____ شهر/يوم/سنة _____
 ذكر انثى المدرسة/الصف: _____
 العنوان: _____ الهاتف: _____
 الشارع _____ الرمز البريدي _____ البيت _____ السيارة _____ العمل _____
 البريد الالكتروني: _____
 اطلاق المعلومات الصحية: امنح موافقتي للمشاركة بنتائج هذا الفحص مع المدرسة _____
 توقيع ولي الامر/مقدم الرعاية _____ التاريخ _____

ملاحظة: فحص دخول الحضانة يتم اجراءه ليس قبل شهر مارس من العام الذي سيدخل الطفل الى الحضانة

COMPLETED BY HEALTH PROVIDER IMMUNIZATION RECORD (EACH child should have a completed or updated official Immunization Record)

Vaccine	Dose Given: Month / Day / Year					<input type="checkbox"/> Child has no risk factors for TB and does not require TB test * Risk factors on reverse Health Provider Signature: _____ Tuberculin Skin Test: <input type="checkbox"/> Mantoux <input type="checkbox"/> IGRA blood test Date: _____ Induration: ___ mm Result: <input type="checkbox"/> Negative <input type="checkbox"/> Positive Chest X-Ray/RX: Required with Positive TB Skin or TB Blood Test CXR Date: _____ Impression: <input type="checkbox"/> Negative <input type="checkbox"/> Positive RX treatment & duration: _____
	1 st	2 nd	3 rd	4 th	5 th	
Polio (IPV)						
DTaP (Diphtheria, Tetanus, Pertussis)						
Td/ Tdap (Tetanus, Diphtheria, Pertussis)						
MMR						
Hib (Haemophilus influenza Type B)						
Hepatitis B						
Hepatitis A (not required)						
Varicella			Had Varicella – Date: _____			

EXAM DATE	SUMMARY OF FINDINGS/CONDITIONS	REFERRALS - F/U
Screenings	Weight: _____ Height: _____ BMI%ile: _____ B/P: _____ Lead: _____ Hgb/Hct: _____ U/A: _____	
Vision/Hearing	Near Vision: R: 20/____ L: 20/____ Both: 20/____ Color Vision (2 nd grade boys): <input type="checkbox"/> Pass <input type="checkbox"/> Fail Distance Vision: R: 20/____ L: 20/____ Both: 20/____ <input type="checkbox"/> Has glasses Hearing: R: <input type="checkbox"/> Pass <input type="checkbox"/> Fail L: <input type="checkbox"/> Pass <input type="checkbox"/> Fail	
Physical Examination	<input type="checkbox"/> Medical condition(s) identified *Specify: _____ <input type="checkbox"/> Medication taken at school: ** _____ <input type="checkbox"/> At home: _____ <input type="checkbox"/> 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/SHM.php <input type="checkbox"/> Examination revealed NO condition relevant to the school program, e.g. allergies, asthma, cardiac, diabetes, epilepsy, other	
Dental Assessment	<input type="checkbox"/> NO dental problems <input type="checkbox"/> Dental problems Specify: _____	
Developmental Assessment	<input type="checkbox"/> Development is within age expectations <input type="checkbox"/> Developmental concern(s) Specify: _____ <input type="checkbox"/> Developmental diagnosis Specify: _____	
Nutritional Assessment		
Other		

Signature/Title of Health Provider	Date / /	Address/Phone (Print/Stamp)
Name (Please print or stamp)		

