

San Francisco Unified School District School Health Form

由家長/看顧人填寫：

學生姓名： _____ 出生日期： _____ 男 女 學校/年級： _____

姓 名

月/日/年

地址： _____ 電話： _____ 電郵： _____

街道

郵區號碼

住所

手提

工作

公開個人健康資料：本人同意與有關學校分享這份體驗報告。

家長/監護人/看顧人簽名

日期

注意：幼稚園學生入學體驗不得早於入學年三月或以前進行。

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: _____ Date: _____
	1 st	2 nd	3 rd	4 th	5 th	
Polio (IPV)						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
DTaP (Diphtheria, Tetanus, Pertussis)						
Td/ Tdap (Tetanus, Diphtheria, Pertussis)						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: _____
MMR						
Hib (Haemophilus influenzae 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	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

Name (Please print or stamp)

Date / /

Address/Phone (Print/Stamp)

