San Francisco Unified School District School Health Form

Kukumpletuhin ng Magulang o Tagapangalaga

Pangalan ng Bata ______________________ Petsa ng Kapanganakan : __________ ☐ Lalaki ☐ Babae Paaralan/Grado: __________

Apelyido Pangalan buwan/araw/taon

Address: ______________________ Telepono: ______________________ E-mail: __________

Kalye Zip Tahanan Cell Trabaho

Paglalabas ng impormasyon sa Kalusugan: Ibinibigay ko ang aking permiso na ibahaga ang mga resulta ng eksamen sa paaralan. ______________ ______

Pirma ng Magulang/Tagapangalaga Petsa

TANDAAN: Kailangang isagawa ang pisikal na eksamenasyon para sa pagpasok sa kindergarten **nang hindi mas maaga sa Marso** ng taon na papasok ang bata sa Kindergarten.

COMPLETED BY HEALTH PROVIDER

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

Vaccine	Dose Given: Month / Day / Year 1st	2nd	3rd	4th	5th
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:__________		

☐ **Child has no risk factors for TB and does not require TB test**

* Risk factors on reverse

Health Provider Signature:______________

Tuberculin Skin Test: ☐ **Mantoux** ☐ **IGRA blood test**

Date:______________

Induration: ___ mm Result: ☐ Negative ☐ Positive

Chest X-Ray/RX: Required with Positive TB Skin or TB Blood Test

CXR Date:__________ Impression: ☐ Negative ☐ Positive

RX treatment & duration: ______________________

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 (2nd grade boys):** ☐ Pass ☐ Fail **Distance Vision:** R: 20/____ L: 20/_____ Both: 20/_____ ☐Has glasses **Hearing:** R: ☐Pass ☐ Fail L: ☐Pass ☐ Fail	
Physical Examination	☐ Medical condition(s) identified *Specify:______________________ ☐ Medication taken at school: **______________________ ☐ 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/SHM.php** ☐ Examination revealed **NO** condition relevant to the school program, e.g. allergies, asthma, cardiac, diabetes, epilepsy, other	
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)		