San Francisco Unified School District School Health Form

EL PADRE/ENCARGADO DEBE LLENAR EL FORMULARIO

Nombre del niño: _____ Fecha de nacimiento: _____ ☐ Masculino ☐ Femenino Escuela/Grado: _____

Apellido, Nombre mes/día/año

Dirección: Teléfono: Correo electrónico:

_____ _____

Calle Código Postal Casa Celular Trabajo

Autorización para divulgar información de salud: Doy autorización de compartir con la escuela los resultados de este examen: _____

Firma del padre/encargado **Fecha**

NOTA: El examen físico para ingresar a kínder **no debe hacerse antes de marzo** del año en que el niño ingresa a kínder

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

	Dose Given: Month / Day / Year				
Vaccine	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: _____ **Date:** _____

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	**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		

Signature/Title of Health Provider **Date / /** **Address/Phone (Print/Stamp)**

Name (Please print or stamp)