HISTORIA YA AFYA YA MWANAFUNZI WA CHEKECHEA
IOWA CITY COMMUNITY SCHOOL DISTRICT

KWA WAZAZI:
Uchunguzi wa afya kabla ya chekechea na mtoa huduma ya afya wa msingi wa mtoto wako ni muhimu kwa afya ya mtoto wako na kwa shule ili iweze kuzoea mpango wake kwa mahitaji ya binafsi. Tafadhali mruhusu mtoto wako achunguzwe kabla ya kuingia shuleni na mara kwa mara baada ya hapo kulingana na mapendekezo ya mtoa huduma ya afya wa msingi wa mtoto wako. Tafadhali jaza sehemu hii ya fomu. Je, mtoa huduma ya afya wa msingi wa mtoto wako amejaza sehemu ya nyuma ya fomu. Rudisha fomu shuleni mwanzo wa mwaka wa shule.

NI JUKUMU LA MZAZI KUTOA CHETI CHA CHANJO YA KILA MTOTO ILIYOKAMILIKA WAKATI AKIINGIA SHULENI!

SEHEMU HII IJAZWE NA MZAZI:

_____ _____ _____ _____/_____/____
Jina la Mwisho la Mtoto Jila la Kwanza la Mtoto Anwani Tarehe ya Kuzaliwa

_____ _____ _____
Daktari wa Mtoto/ NP/ PA Simu Pendeleo la Hospitali

_____ _____
Daktari wa Meno wa Mtoto Simu

Je, mtoto wako na chochote kati ya hivi vifuatavyo, au ana historia ya chochote kati ya vifuatavyo? Iwapo jibu ni ndiyo, tafadahali lielezee kwa mapana hapa chini:

	NDIYO	LA				
1.	___	___	Pumu			
2.	___	___	Mishtuko			
3.	___	___	Kisukari			
4.	___	___	Matatizo ya moyo			
5.	___	___	Mfadhaiko/Wasiwasi			
6.	___	___	ADD/ADHD			
7.	___	___	Mizio ya chakula, dawa, miba ya nyuki, yumbi/chavuo			
8.	___	___	Maumivu ya kichwa			
9.	___	___	Matatizo ya kuona	huvaa miwani_____	huvaa miwani ya konea_____	
10.	___	___	Matatizo ya kusikia	sikio la kushoto_____	sikio la kulia_____	vifaa vya kusikia_____
11.	___	___	Matatizo ya kula/kuzingatia lishe			
12.	___	___	Tatizo la tumbo/kibofu			

Maelezo ya undani ya hali za afya ambazo ulijibu “ndivo” hapo juu: _____

_____

KINDERGARTEN STUDENT HEALTH STATUS
IOWA CITY COMMUNITY SCHOOL DISTRICT

NAME _____ BIRTHDATE_____/_____/_____ DATE OF EXAMINATION___ /_____/_____

THIS SIDE TO BE COMPLETED BY PHYSICIAN, NURSE PRACTITIONER, or PHYSICIAN ASSISTANT:
I hereby certify that the above named child was examined by me within the past twelve months and is able to participate in the school program of the Iowa City Community School District. YES [ ] NO [ ]

Height_____ Weight_____ Blood Pressure_____ Hearing_____
Vision – _____(Please complete Iowa Certificate of Vision Screening)

CONCERNS/ RESTRICTIONS:

1. Does this child have any vision, hearing, or speech concerns that the school should be aware of and/or make accommodations for? YES [ ] NO [ ] Needs further evaluation? YES [ ] NO [ ]	If yes or further evaluation is needed, please describe:
2. Does this child have any condition which may affect the child's participation in: Classroom activities? YES [ ] NO [ ] Physical education/physical activities? YES [ ] NO [ ]	If yes, please describe:
3. Does this child have any condition which may result in a classroom emergency, i.e. asthma, seizures, fainting, diabetes, etc. ? YES [ ] NO [ ]	If yes, please describe:
4. Is there any emotional, mental, or physical condition for which this child should remain under periodic medical observation? YES [ ] NO [ ] Needs further evaluation? YES [ ] NO [ ]	If yes or further evaluation is needed, please describe:
5. Teeth and gums: _____ No obvious problems _____Requires dental care _____Requires urgent dental care	Referral made to:
6. Are immunizations up to date? YES [ ] NO [ ]	If no, please identify missing immunizations and plans for bringing up to date:
7. Has this child received a blood lead screening test, as required by Iowa law? YES [ ] NO [ ]	If so, please give the date and result of the lead screening, and plan for follow up if needed:

_____ _____ _____ _____
Physician, NP, or PA Name (Printed) Phone Physician, NP, or PA Signature Today's Date

Revised 2014