



Name of Child (Last, First, Middle)	Birth Date
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PART II — MEDICAL EVALUATION

To be completed and signed by the Health Care Provider ONLY:

The child named above has had a complete history and physical exam on the following date:

(Exam must be within one year of enrollment)

_____ Month _____ Day _____ Year

Screening Results:

Height: _____ Weight: _____ BMI%: _____ B/P: _____ Hct/Hgb: _____ Lead: _____ Urinalysis: _____

Vision - Without Glasses	Right 20/_____	Left 20/_____	Passed <input type="checkbox"/>	Failed <input type="checkbox"/>	Referred <input type="checkbox"/>	Hearing – Right	Passed <input type="checkbox"/>	Failed <input type="checkbox"/>	Referred <input type="checkbox"/>
Vision - With Glasses	Right 20/_____	Left 20/_____	Failed <input type="checkbox"/>	Referred <input type="checkbox"/>		Hearing – Left	Passed <input type="checkbox"/>	Failed <input type="checkbox"/>	Referred <input type="checkbox"/>

- | | | | | |
|-------------------------------|---------------------------------|-----------------------------------|-------|-----------------|
| Gross dental (teeth and gums) | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal | _____ | Refer/Tx: _____ |
| Head/scalp/skin | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal | _____ | Refer/Tx: _____ |
| Eyes/Ears/Nose/Throat | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal | _____ | Refer/Tx: _____ |
| Chest/Lungs/Heart | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal | _____ | Refer/Tx: _____ |
| Abdomen | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal | _____ | Refer/Tx: _____ |
| Postural assessment | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal | _____ | Refer/Tx: _____ |

TB risk assessment done (Please review Targeted Testing Guidelines listed below.)

This child has the following problems that may impact the educational experience:

- Vision Hearing Speech/Language Physical Social/Behavioral Cognitive

Specify: _____

This child has a health condition that may require emergency action at school, e.g. seizures, allergies. Specify below.

(This form will be stored in the child's Cumulative Health Folder and may be accessed by both school and health personnel.)

Recommendations (Attach additional sheet if necessary): _____

(Please Check One)

- This child may participate fully in school activities including physical education.
 This child may participate in school activities including physical education with the following restriction/adaptation.

(Specify reason and restriction) _____

Signature/Title of Health Care Provider	Date	Address (Please print or stamp)
<input checked="" type="checkbox"/>	___/___/___	
Name (Please print or stamp)		

Tuberculosis Targeted Testing Guidelines for Health Care Providers

Tuberculosis Infection Risk:

Review the following risks and administer a Mantoux TB skin test if child is in one or more categories. The TB test is administered confidentially as part of the health examination. **Do not record administration of any TB test or related information on this form.**

- Recent immigrant (< 5 years), frequent visitor to TB endemic areas
- Close contact to active TB case
- Frequent contact with adults at high-risk for disease, HIV+, homeless, incarcerated, illicit drug user
- HIV+ or have other medical conditions that increase the risk to progress from infection to disease, e.g., chronic renal failure, diabetes, hematologic or any other malignancy, weight loss > 10% of ideal body weight, on immunosuppressive medications

Active TB Disease Risk:

- Does the child exhibit signs/symptoms of tuberculosis (e.g. cough for three weeks or longer, weight loss, loss of appetite)?
- If symptoms are present, work-up or refer for TB disease evaluation.