

The items below are required to complete your child's registration. If you have previously turned them in, you do not have to do so again.

- Copy of Certified Birth Certificate
- Copy of Social Security card
- KY Dental Screening/Exam Form for School Entry
(completed by a Dentist, Dental Hygienist, Physician,
Registered Nurse, ARNP, or P.A.)
- KY Eye Exam for School (by Optometrist of your choice)
- Preventative Health Care Exam Form (completed by a
Doctor or Health Dept)
- Immunization Record up-to-date
- Guardian paperwork, if any

PREVENTATIVE HEALTH CARE EXAMINATION FORM

All local boards of education shall require a preventative health care examination of each child first entering a Kentucky public school within a period of twelve (12) months prior to initial admission to school and within one (1) year prior to entry to sixth grade. Local school boards may extend this time not to exceed two (2) months. (702 KAR 1:160)

PLEASE COMPLETE THE IDENTIFYING INFORMATION AND RECORDS

IDENTIFYING INFORMATION

Student Name: _____ Gender: **M** **F** Grade: _____
 Date of Birth: _____ Age: _____ yrs _____ months Preferred Language: _____
 Parent or Guardian Name: _____

RECORD OF IMMUNIZATIONS TO BE REPORTED ON IMMUNIZATION CERTIFICATE FORM, EPID 230.

MEDICAL HISTORY

Allergies: _____

Current Prescribed Medications to be taken daily at school: _____

Significant Historical Information: _____

SCREENING RESULTS:

Height: _____ ft _____ inches Weight _____ BMI: _____ BMI% _____ B/P: _____

Vision	Right 20/_____	Passed ☐	Hearing – Right	Passed ☐	Failed ☐	Referred ☐
	Left 20/_____	Failed ☐		Passed ☐	Failed ☐	Referred ☐
		Referred ☐	Hearing - Left	Passed ☐	Failed ☐	Referred ☐

Optional: Hct/HGB: _____ Lead: _____ Urinalysis: _____

Gross dental (teeth and gums)	☐ Normal ☐ Abnormal	Refer/Tx: _____
Head/scalp/skin	☐ Normal ☐ Abnormal	Refer/Tx: _____
Eyes/Ears/Nose/Throat	☐ Normal ☐ Abnormal	Refer/Tx: _____
Chest/Lungs/Heart	☐ Normal ☐ Abnormal	Refer/Tx: _____
Abdomen	☐ Normal ☐ Abnormal	Refer/Tx: _____
Scoliosis assessment	☐ Normal ☐ Abnormal	Refer/Tx: _____

(Over)

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.

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) _____

ANTICIPATORY GUIDELINES

Discussed and/or handout given

☐ **SCHOOL READINESS**

- Establish routines
- After-school care/activities
- Friends
- Bullying
- Communicate with teachers

☐ **MENTAL HEALTH**

- Family time
- Anger management
- Discipline for teaching not punishment
- Limit TV, computer

☐ **NUTRITION AND PHYSICAL ACTIVITY**

- Healthy weight
- Well-balanced diet, including breakfast
- Fruits, vegetables, whole grains, dairy

- 60 minutes of exercise/day

☐ **ORAL HEALTH**

- Regular dentist visits
- Brushing/Flossing
- Fluoride

☐ **SAFETY**

- Sexual safety
- Pedestrian safety
- Safety helmets
- Swimming safety
- Fire escape plan
- Smoke/carbon monoxide detectors
- Guns
- Sun
- Appropriately restrained in all vehicles

Additional comments or recommendations: _____

Signed: _____
Physician/APRN/PA/EPSDT Provider

Date: _____

Address: _____

Telephone: _____

KRS 156.160 (1) (g) requires proof of a vision examination by an optometrist or ophthalmologist. This evidence shall be submitted to the school no later than January 1 of the first year that a three (3), four (4), five (5) or six (6) year old child is enrolled in public school, public preschool, or Head Start program.

PLEASE COMPLETE THE IDENTIFYING INFORMATION

Date of student's enrollment: _____

Date of Vision Examination: _____

IDENTIFYING INFORMATION

Student Name: _____

Date of Birth: _____

Parent or Guardian Name: _____

CASE HISTORY

Date of Exam: _____

Ocular History: Normal or Positive for: _____

Medical History: Normal or Positive for: _____

Drug Allergies: NKDA or Allergic to: _____

Family Ocular and Medical History: ☐ Amblyopia ☐ Strabismus ☐ Glaucoma ☐ Diabetes

Other: _____

Other Pertinent Information: _____

Refraction with cycloplegic? (Please indicate one.) ☐ YES ☐ NO

	OD	OS
Unaided Acuity	20/	20/
Best Corrected Acuity	20/	20/

Type of Examination	Normal	Abnormal	Notable to Assess
External-Exam (eye and adnexa)			
Internal Exam (media, lens, fundus, etc)			
Neurological Integrity (pupils)			
Binocular Function (stereopsis)			
Accommodation and convergence			
Color Vision			

Diagnosis:

☐ Normal ☐ Myopia ☐ Hyperopia ☐ Astigmatism ☐ Strabismus ☐ Amblyopia

Other: _____

Recommendations:

1 Glasses prescribed: ☐ YES ☐ NO

2 _____

3 _____

Age appropriate and suggested anticipatory guidance (health assessments):

- ☐ Educate (parents/patients) about eye/vision disorders and needed vision care
- ☐ Counsel (parents/patients) regarding eye safety
- ☐ Stress importance of early, preventative eye care
- ☐ Recommend re-examination, as appropriate

Signed: _____

Optometrist/Ophthalmologist

Date: _____

Address: _____

Telephone: () _____

Kentucky law, KRS 156.160(i), requires proof of a dental screening or examination by a dentist, dental hygienist, physician, registered nurse, advanced registered nurse practitioner, or physician assistant. This evidence shall be presented to the school no later than January 1 of the first year that a five (5) or six (6) year old is enrolled in public school.

Student Name: _____ Last First Middle Birth date: ____/____/____ Gender: ☐ 0 Male ☐ 1 Female Parent or Guardian: _____ Name Relationship Address: _____ City: _____ Phone Number: _____ School: _____ Date of Exam/Screening ____/____/____		Test Type (check one) ☐ Screening ☐ Exam
Screener's Name: _____ Screener's Address: _____ Phone Number: _____ Screening Date: _____ Screener's Signature: _____		Professional affiliation: (Please check one) ☐ Dentist ☐ Dental Hygienist ☐ Physician Assistant ☐ LHD Registered Nurse with KIDS Smiles training ☐ APRN ☐ Physician
Untreated Decay: (Check one) ☐ 0 No untreated cavities ☐ 1 Untreated cavities		
Pattern of Early Childhood Cavities: (Check one) ☐ 0 No Early Childhood Cavities ☐ 1 Early Childhood Cavities Present		Comments:
Treated Decay: (Check one) ☐ 0 No treated cavities ☐ 1 Treated cavities		
Treatment Urgency: (Check one) ☐ 0 No obvious problem ☐ 1 Early dental care needed ☐ 2 Referral for Urgent Care NOTE: Comment required if marked.		