



### STATE OF FLORIDA School Entry Health Exam

**To Parent/Guardian:** Please complete and sign Part I — Child’s Medical History.  
State law for school entry requires a health examination by a legally qualified professional. Additional requirements may be determined by local school districts.

*(Please Print)*

Name of Child (Last, First, Middle)		Birth Date	Sex
Address (Street)		School	Grade
City and ZIP Code	Home Telephone Number	Parent/Guardian (Last, First, Middle)	

#### PART I — CHILD’S MEDICAL HISTORY

**To Parent/Guardian:** Please check answers to questions 1 through 8 below in the column on the left.  
*(Please explain any “Yes” answers in the space provided below.)*

1. Yes  No  Any concerns about general health (eating and sleeping habits, weight, etc.)?
2. Yes  No  Any other specific illness or social/emotional or behavioral problems?
3. Yes  No  Any allergies (food, insects, medication, etc.)?
4. Yes  No  Any prescription medication (daily or occasionally)?
5. Yes  No  Any problems with vision, hearing, or speech (glasses, contacts, ear tubes, hearing aids)?
6. Yes  No  Any hospitalization, operation, or major illness (specify problem)?
7. Yes  No  Any significant injury or accident (specify problem)?
8. Yes  No  Would you like to discuss anything about your child’s health with a school nurse?

**To Parent/Guardian:** Please explain any “Yes” answers from above.

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**I am the parent/guardian of the child named above. I give permission for the information on PARTS I and II of this form provided about my child to be reviewed and utilized only by the staff of this school and any school health personnel providing school health services in the district for the limited purpose of meeting my child’s health and educational needs.**

\_\_\_\_\_  
Signature of Parent/Guardian
Date

#### Partnership for School Readiness Recommendations for Prekindergarten and Kindergarten

**To Parent/Guardian:** Please obtain the services listed below in order to find any problems. Please work with your health care provider to correct or treat any problems that may reduce your child’s ability to learn in school. **(These services are recommended but not required.)**

1. Comprehensive Vision Examination (3-5 years of age) Date of Exam: _____ Results of Exam: _____ _____ Health Care Provider: _____ (check one) Optometrist <input type="checkbox"/> Ophthalmologist <input type="checkbox"/>	Please describe any corrective action for any problems detected and any accommodations required.
2. Comprehensive Dental Examination Date of Exam: _____ Results of Exam: _____ _____ Dentist: _____	Please describe any corrective action for any problems detected and any accommodations required.
3. Hearing Screening Date of Exam: _____ Results of Exam: _____ _____ Health Care Provider: _____	Please describe any corrective action for any problems detected and any accommodations required.