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
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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.

________________________________________________________________________

________________________________________________________________________

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 □ Ophthalmologist □
   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.