

Report of Medical Examination for School Entry

California law requires a medical examination for school entry to protect the health of all children.

Please return this report to the school. All personal information will be kept confidential.

PART I TO BE	FILLED OUT BY PA	RENT OR GUAR	DIAN/ Españo	ol al doi	rso	
CHILD'S NAME-	–Last	First	Middle I	Initial	School	
			:	;	4	
ADDRESS—Numb	ber, Street	City	ZIP Cod	le :	Birth Date—Month/Day/	l'ear
				,		
	1. 1 11 1					
NOTICE AND ADDRESS OF THE PARTY	dical provider to compledical provider to compl		rt III			1
i want the me	dicai provider to compi	ele Part II only	Sig	gnature	of Parent or Guardian	Date
PART II TO BE	FILLED OUT BY T	HE MEDICAL PR			Barrier (19 1 7) (1917)	
7	Tests and Evaluation	ıs	Date	Name	Medical Provider Info e, Address, and Telephon	
Child's Height	Child's Weight	Child's BMI			, rudiess, and reception	e ivaniber.
inches	lbs	Percentile %				
Health/Developmen		020				
Physical Examination				1		
Nutritional Evaluati						
Vision Screening						
Audiometric Screen	ning					
Blood Test for Aner	mia	A CONTRACTOR OF THE PROPERTY O		1		
Urine Dipstick						
Dental Screening						1
Tuberculin (TB) Ski	in Test (Recommended for ALL	children entering first grade)		Sign	nature of Medical Profess	ional Date
CHILD HAS A CO	OMPLETED OR UPDA	TED YELLOW CA	LIFORNIA IMA	MUNIZ	ATION RECORD	YES □ NO
(CALCANIA CARACTER AND	E FILLED OUT BY T		TANK MANAGEMENT IN PROPERTY OF THE PARTY OF		kale september et et et e	
AND DESCRIPTION OF THE PERSON				ermissio	on of the parent or guardia	n—it is
recommended that	significant health inform		•		act the school nurse if the	
with medication at		. 🗖 🗃		4.00		
- T	sts Part III not be filled ou nat need further evaluation				of importance to school or	physical activity.
- Conditions in	iat need further evaluation	or that can affect sci	iooi or physical a	activity a	re (piease expiain):	
	77.	AIVER OF MED	CAL EXAMI	NATIO	N	
Note: Y					no health examination is g	iven.
I have been told al	bout the medical exami	nation recommende	ed by health pro	ofession	als and required by State	
	Security of the second section of the section			ost, if s	uch assistance is needed.	
	t my child to receive a r			404 :4	haana	
I do want my	child to receive a medi	ical examination, of	it i aili ullable i	to get n	because	
			1			
		CONTRACTOR AND PLANTAGE AND PROPERTY OF THE STREET	/			
Signatu	are of Parent or Guardia	n			Date	

County of San Diego Health and Human Services Agency, 3851 Rosecrans Street, Suite 522, MS: P511-H, San Diego, CA 92110

For more information, please call 619-692-8808

Oral Health Assessment Form

California law (*Education Code* Section 49452.8) states your child must have a dental check-up by May 31 of their first year in public school. A California licensed dental professional operating within their scope of practice must perform the check-up and fill out Section 2 of this form. If your child had a dental check-up in the 12 months before they started school, ask your dentist to fill out Section 2. If you are unable to get a dental check-up for your child, fill out Section 3.

Section 1: Child's Information (Filled out by parent or guardian)

Address: City: School Name: Teacher: Grade: Child's Sex: Male Female Parent/Guardian Name: Child's race/ethnicity: White Black/African American Hispanic/Latino Asian Native American Multi-racial Other Native American Multi-racial Other Unknown	Child's First	t Name:	Last Name:		Middle Initial:	Child's birth da	ate:
School Name: Teacher:	Address:			· ·		Apt.:	
Parent/Guardian Name: Child's race/ethnicity: White Black/African American Hispanic/Latino Asian Native American Multi-racial Other Unknown	City:			<u> </u>		ZIP code:	
Parent/Guardian Name: Child's race/ethnicity: White Black/African American Hispanic/Latino Asian Native American Multi-racial Other Native Hawaiian/Pacific Islander Unknown	School Nam	ne:	Teacher:		Grade:		- Fomelo
PORTANT NOTE: Consider each box separately. Mark each box. Seessment ate:	Parent/Gua	rdian Name:	□ White □ □ Native A	Black/African America American □ Multi-ra	cial 🛮 Other	/Latino □ Asi	
Caries Experience (Visible decay and/or fillings present)			•	•	rnia licensec	dental prof	essiona
Pes	ssessment	Caries Experience (Visible decay and/or	Visible Decay	Treatment Urgency: □ No obvious proble □ Early dental care	em found recommended (c		
ection 3: Waiver of Oral Health Assessment Requirement be filled out by parent or guardian asking to be excused from this requirement Please excuse my child from the dental check-up because: (Check the box that best describes the reason) I am unable to find a dental office that will take my child's dental insurance plan. My child's dental insurance plan is: Medi-Cal/Denti-Cal Other: None I cannot afford an oral health screening for my child. I do not want my child to receive an oral health screening.		□ Yes □ No	□ Yes □ No				
ection 3: Waiver of Oral Health Assessment Requirement be filled out by parent or guardian asking to be excused from this requirement Please excuse my child from the dental check-up because: (Check the box that best describes the reason) I am unable to find a dental office that will take my child's dental insurance plan. My child's dental insurance plan is: Medi-Cal/Denti-Cal Other: None I cannot afford an oral health screening for my child. I do not want my child to receive an oral health screening.							
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My child's dental insurance plan is:	be filled ou	ıt by parent or guardian	asking to be ex	xcused from this red	<u></u>	es the reason)	
□ I cannot afford an oral health screening for my child. □ I do not want my child to receive an oral health screening.				e my child's dental ins	urance plan.		
□ I do not want my child to receive an oral health screening.		Medi-Cal/Denti-Cal	□ Other:		□ None		
□ Optional: other reasons my child could not get an oral health screening:	□ I do	not want my child to recei	ve an oral healt	h screening.			•
	□ Optio	onal: other reasons my ch	ild could not ge	t an oral health scree	ning:		
Please sign if asking to waive Oral Health Assessment Requirement:	. *				Signature of pa	arent or guardia	an Date

The law states schools must keep student health information private. Your child's name will not be part of any report as a result of this law. This information may only be used for purposes related to your child's health. If you have questions, please contact your school office.

Return this form to the school *no later than* May 31 of your child's first school year.

Original to be kept in child's school record.

County of San Diego, Health and Human Services Agency, Public Health Services, Maternal, Child, and Family Health Services
For more information, please call (619) 692-8808

