11232 El Camino Real
San Diego, CA 92130-2657
(858) 755-9301
(858) 723-6114 Fax
www.dmusd.org

Student Services
Fax (858) 755-4361

Del Mar union school district
Igniting Genius, Empowering Students

Report of Medical Examination for School Entry

Dear Parent or Guardian:

California State Law (AB2068) has established the Child Health and Disability Program (CHDP). The intent of this program is to prevent, diagnose, and correct many health problems found in children and young people.

The law requires that parents present their school district with a completed *Report of Medical Examination for School Entry* form before their child enters the first grade, however, Del Mar Union School District asks that the examination be completed before your child begins kindergarten. A copy of the examination form is attached for your use. All parents should note that if they do not wish to have their child examined, they may sign the *Waiver of Medical Examination* located on the bottom portion of the form. However, we recommend that all children be examined. The screening may be completed by your personal physician or at the Health Department for a nominal fee.

Parents who feel that they may be eligible for a CHDP reimbursed health check-up service are asked to call the nurse who serves their child's school site.

Hearing and vision tests will be completed by the school nurse.

Please assist us in complying with CHDP requirements by completing the attached *Report of Medical Examination for School Entry* form and returning it to your child's school as soon as possible.

Sincerely,

Lori Cummins

Lori Cummins
Director of Student Services

Attachment

School Entry Health Checkup Requirement

Early and regular **health checkups** can find, prevent, and treat many health problems before they become serious. That is why California has a **law** that says all children **must** have a health checkup within **18 months before first grade or up to 90 days after starting first grade**. Your child must also have certain immunizations, or shots, for school. Your doctor will be able to check your child's immunization record and see what shots are needed during the health checkup. Your doctor will complete this form and you need to return to your child's school.

If you are not able to pay for this checkup, please call Maternal Child and Family Health services to find out if your child is eligible for a health checkup at no cost and for ongoing medical and dental insurance.

1-800-675-2229

PART I – TO BE FILLED OUT BY THE PARENT/GUARDIAN

CHILD'S NAME: Last	First	Middle Initial
Birth Date (MM/DD/YYYY)	School	
ADDRESS – Number, Street	City	Zip

☐ I want the medical provider to complete **Part II only**.

PART II – TO BE FILLED OUT BY THE MEDICAL PROVIDER

Tests and Evaluations			**Date of Exam**	**MEDICAL PROVIDER INFORMATION**
Height _____ inches	Weight _____ lbs _____ ozs	BMI Percentile _____%		
Health/Development History				Name, Address, and Telephone Number:
Physical Examination				
Nutritional Evaluation				
Vision Screening				
Audiometric Screening				
Blood Test for Anemia				
Urine Dipstick/Urinalysis				
Dental Screening				/
Tuberculin (TB) Skin Test/Risk Assessment				Signature of Medical Professional / Date

DOES CHILD HAVE A COMPLETED AND UPDATED YELLOW CALIFORNIA IMMUNIZATION RECORD? ☐ **Yes** ☐ **No**

PART III – TO BE FILLED OUT BY THE MEDICAL PROVIDER

Other health information (optional): For child's welfare and with the permission of the parent or guardian, it is recommended that significant health information be shared with the school. *Please contact the school nurse if child needs help with medication at school.*

☐ Parent requests Part III not to be filled out
☐ The examination revealed no conditions of importance to school or physical activity.
☐ Conditions that need further evaluation or that can affect school or physical activity are (please explain below)

WAIVER OF MEDICAL EXAMINATION

I have been told about the medical examination recommended by health professionals and required by State law. I have also been told where and how my child can receive medical examinations at no cost, if such assistance is needed.

__ **I do not want** my child to receive a medical examination
__ **I do want** my child to receive a medical examination, **but I am unable to get it because** _____

_____ _____
Signature of Parent or Guardian *Date*

County of San Diego, Health and Human Services Agency, 3851 Rosecrans St., Ste. 522, San Diego, CA 92110
For more information, please call (619) 692-8808

LIVE WELL SAN DIEGO

Requisitos para Exámenes de Salud para Ingresar a la Escuela

Al recibir **exámenes de salud** regularmente se pueden prevenir, detectar, y tartar muchos problemas de salud antes de que sean serios. Por esta razón California tiene una ley que requiere que todos los niños deben recibir un examen de salud **18 meses antes de ingresar al primer año o hasta 90 días después de haber iniciado el primer año**. Su niño debe tener ciertas vacunas para ingresar a la escuela. Su medico podrá revisar la tarjeta amarilla de vacunación y ver que vacunas necesita durante el examen de salud. Su medico llenará esta forma y usted deberá entregarla a la escuela de su niño. **Si su niño recibió el examen de salud** al ingresar al jardín de niños (kindergarten) y la escuela todavía no tiene el reporte del examen, usted necesita pedírselo a su medico o clínica y llevarlo a la escuela.

Si a Ud. no le es possible pagar el examen, por favor llame a los Servicios de Salud Maternal, Niño, y Familia para saber si su niño califica para un examen fisico gratuito y también para un seguro de cuidado continuo medico y dental al:

1-800-675-2229

LA PARTE I DEBERA SER LLENADA POR EL PADRE O GUARDIAN (*PARENT OR GUARDIAN)*

NOMBRE DEL NIÑO-Appellido	Nombre	Segundo Nombre
Fecha de Nacimiento (DD/MM/YYYY)	Escuela	
DOMICILIO-Número, Calle	Ciudad	Zona Postal

☐ Yo solicito que el proveedor medico complete **la Parte II solamente.**

LA PARTE II EL PROVEEDOR MÉDICO DEBERA LLENAR (*MEDICAL PROVIDER)*

Tests and Evaluations *(Pruebas y evaluciones)*			**Date of Exam** *(Fecha de Examen)*	**MEDICAL PROVIDER INFORMATION** *(Información de Proveedor Médico)*
Height (Estatura) _____ inches	Weight (Peso) _____ lbs _____ ozs	BMI Percentile (El porcentaje de Índice de Masa Corporal) _____%		
Health/Development History *(Historial Médico/Desarrollo)*				Name, Address, and Telephone Number:
Physical Examination *(Examen Físico)*				
Nutritional Evaluation *(Evaluacón de Nutrición)*				
Vision Screening (*Examen de la Vista)*				
Audiometric Screening (*Examen Audiométrico)*				
Blood Test for Anemia *(Análisis de Sangre para Anemia)*				
Urine Dipstick/Urinalysis (*Análisis de Orina)*				
Dental Screening (*Evaluación Dental)*				/
Tuberculin (TB) Skin Test/Risk Assessment *(Prueba de Tuberculina)*				Signature of Medical Professional / Date

DOES CHILD HAVE A COMPLETED AND UPDATED YELLOW CALIFORNIA IMMUNIZATION RECORD? ☐ **Yes** ☐ **No**
(¿TIENE EL NIÑO(A) UNA TARJETA COMPLETA ACTUALIZADA DE VACUNACIÓN DE CALIFORNIA?)

LA PARTE III EL PROVEEDOR MÉDICO DEBERA LLENAR *(MEDICAL PROVIDER)*

Other health information (optional): For child's welfare and with the permission of the parent or guardian, it is recommended that significant health information be shared with the school. *Please contact the school nurse if child needs help with medication at school.*

☐ Parent requests Part III not to be filled out
☐ The examination revealed no conditions of importance to school or physical activity
☐ Conditions that need further evaluation or that can affect school or physical activity are (please explain below)

FORMA PARA REHUSAR EL EXAMEN DE SALUD *(WAIVER OF EXAMINATION)*

Nota: Su niño(a) debe recibir las vacunas requeridas por la ley Estatal, aunque no reciba el examen médico.
He sido informado acerca del examen médico recomendado por los profesionales de salud y que es requerido por la ley Estatal. También he sido informado en dónde y cómo mi niño(a) puede recibir un examen médico sin costo alguno, si tal asistencia fuera necesaria.

__ **No deseo** que mi niño(a) reciba un examen médico
__ **Si deseo** que mi niño(a) reciba el examen médico, **pero me ha sido imposible obtenerlo porque** _____

_____ _____
Firma del Padre, Madre, o Guardián *Fecha*