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,

Cara Schukoske
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

CHLDR’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

<table>
<thead>
<tr>
<th>Tests and Evaluations</th>
<th>Date of Exam</th>
<th>MEDICAL PROVIDER INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Height ______ inches</td>
<td>Weight _____ lbs _____ ozs</td>
<td>Subject ______ %</td>
</tr>
</tbody>
</table>

Health/Development History

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

Child Health and Disability Prevention Program

MCFHS – 77ES 01/2015
Requisitos para Exámenes de Salud para Ingresar a la Escuela

Al recibir exámenes de salud regularmente se pueden prevenir, detectar, y tratar 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 médico podrá revisar la tarjeta amarilla de vacunación y ver que vacunas necesita durante el examen de salud. Su médico 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 médico o clínica y llevarlo a la escuela.

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

1-800-675-2229

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

<table>
<thead>
<tr>
<th>NOMBRE DEL NIÑO-Appellido</th>
<th>Nombre</th>
<th>Segundo Nombre</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fecha de Nacimiento (DD/MM/YYYY)</td>
<td>Escuela</td>
<td></td>
</tr>
<tr>
<td>DOMICILIO-Número, Calle</td>
<td>Ciudad</td>
<td>Zona Postal</td>
</tr>
</tbody>
</table>

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

LA PARTE II EL PROVEEDOR MEDICO DEBERÁ LLENAR (MEDICAL PROVIDER)

Tests and Evaluations (Pruebas y evaluaciones)

<table>
<thead>
<tr>
<th>Height (Estatura)</th>
<th>Weight (Peso)</th>
<th>BMI Percentile (El porcentaje de Índice de Masa Corporal)</th>
<th>Date of Exam (Fecha de Examen)</th>
</tr>
</thead>
<tbody>
<tr>
<td>_______ inches</td>
<td>_______ lbs</td>
<td>_______%</td>
<td></td>
</tr>
</tbody>
</table>

Health/Development History (Historial Médico/Desarrollo)

Physical Examination (Examen Físico)

Nutritional Evaluation (Evaluación 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)

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

LA PARTE III EL PROVEEDOR MEDICO DEBERÁ LLlenar (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

☐ Sí deseo que mi niño(a) reciba el examen médico, pero me ha sido imposible obtenerlo porque ____________________________________________________________

______________________________  ____________________________
Firma del Padre, Madre, o Guardián  Fecha

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