



# 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 PARENT OR GUARDIAN/ Español al dorso

CHILD'S NAME—Last	First	Middle Initial	School
ADDRESS—Number, Street	City	ZIP Code	Birth Date—Month/Day/Year

- I want the medical provider to complete **Part II and Part III**
- I want the medical provider to complete **Part II only**

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

## PART II TO BE FILLED OUT BY THE MEDICAL PROVIDER

Tests and Evaluations	Yes	No	Medical Provider Information
			Name, Address, and Telephone Number:
Health/Development History			
Physical Examination			
Nutritional Evaluation			
Vision Screening			
Audiometric Screening			
Blood Test for Anemia			
Urine Dipstick			
Dental Assessment			
Tuberculin (TB) Skin Test (Recommended for ALL children entering first grade)			

**CHILD HAS A COMPLETED OR UPDATED YELLOW CALIFORNIA IMMUNIZATION RECORD**       YES     NO

## PART III TO BE FILLED OUT BY THE MEDICAL PROVIDER

**Other Health Information (Optional):** For the 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 the child needs help with medication at school.*

- Parent requests Part III not 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*):

### WAIVER OF MEDICAL EXAMINATION

**Note: Your child must have immunizations required by State law, even if no health examination is given.**

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, P.O. Box 85222, MS: P511-H, San Diego, CA 92186-5222

**For more information, please call 619-692-8808**