TILLAMOOK ADVENTIST SCHOOL

SCHOOL ENTRY HEALTH FORM

To Parent/Guardian: Please complete and sign Part I – Child's Medical History.
(Please Print)

Name of Child (Last, First, Middle)		Birth Date	Sex
Address (Street)		City and State	Zip
Home Telephone	Cell Phone	Parent/Guardian (Last, First, Middle)	

PART I – CHILD'S MEDICAL HISTORY

To Parent/Guardian: Please check answers to questions 1-7 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)?

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 for the limited purposes 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. Vision Evaluation by optometry if suggested by primary care physician, or if you have concerns about your child's eyes Date of Exam: _____ Results of Exam: _____ _____ Health Care Provider: _____ *(check one)* Optometrist ☐ Ophthalmogolist ☐	Please describe any corrective action for any problems detected and any accommodations required.
2. Comprehensive Dental Examination & Cleaning Date of Exam: _____ Results of Exam: _____ _____ Dentist: _____	Please describe any corrective action for any problems detected and any accommodations required.

4300 12th St, Tillamook, OR 97141 * info@tillamookadventistschool.org * Ph 503.842.6533 * fax 503.842.6236

Name of Child (Last, First, Middle)	**Birth Date**

Part II – MEDICAL EVALUATION

To be completed and signed by the Health Care Provider ONLY:

The child named above has had a complete history and physical exam on the following date: _____ _____ _____
(Exam must be within one year of enrollment) Month Day Year

Screen Results:
Height: _____ Weight: _____ Heart Rate: _____ BMI%: _____ O_2: _____

Vision – Without Glasses	Right 20/____	Left 20/____	Passed ☐ Failed ☐ Referred ☐	Hearing - Right	Passed ☐ Failed ☐ Referred ☐
Vision – With Glasses	Right 20/____	Left 20/____		Hearing - Left	Passed ☐ Failed ☐ Referred ☐
Hearing	Subjectively Normal: ☐ Yes ☐ No				

Gross dental (teeth and gums)	☐ Normal	☐ Abnormal _____	Refer/Tx: _____
Head/scalp/skin	☐ Normal	☐ Abnormal _____	Refer/Tx: _____
Eyes/Ears/Nose/Throat	☐ Normal	☐ Abnormal _____	Refer/Tx: _____
Heart	☐ Normal	☐ Abnormal _____	Refer/Tx: _____
Lungs	☐ Normal	☐ Abnormal _____	Refer/Tx: _____
Abdomen	☐ Normal	☐ Abnormal _____	Refer/Tx: _____
Musculo-skeletal	☐ Normal	☐ Abnormal _____	Refer/Tx: _____

This child has the following problems that may impact the education experience:

☐ Vision ☐ Hearing ☐ Speech/Language ☐ Physical ☐ Social/Behavioral ☐ Cognitive

Specify: _____

_____

☐ This child has a health condition that may require emergency action at school, e.g. seizures, allergies. Specify below.

_____

Recommendations (Attach additional sheet if necessary) _____

_____

_____

_____

(Please Check One)

☐ This child may participate fully in school activities including physical education.

☐ This child may participate in school activities including physical education with the following restrictions/adaptations.

(Specify reason and restriction) _____

_____

Immunizations: ☐ Up to date ☐ Not current Catch up schedule: _____

Signature/Title of Health Care Provider	**Date**	Address (Please print or stamp)
	___ / ___ / ___	
Name (Please print or stamp)		

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