New Student ☐ Returning Student ☐
Px _____ Imms_____ D _____

Student Health Information Sheet

McSwain Union Elementary School District

Date of Registration: (Fecha deRegistacion)_____Grade of Student(Grado del Estudiante)_____

Name: _____
Last (Apellido) First (Nombre) Middle

Address: _____
Street (calle) P.O. Box

_____
City (Ciudad y Estado) State Zip

Personal: _____
Birth Date (Fecha de nacimiento) Sex

_____
Father's Name(Nombre Padre) Mother's Name(Nombre Madre)

Health History to be Completed and Signed by Parent/Guardian

Historial De Salud Paraser Completado Y

Diagnosis of Asthma?Diagnosis de Asma? Wheezing/Cough with activity?Ronquido ?	Yes/No Yes/No	Loss of One of Paired Organs? Perdida De uno los pares deOrganos?	Yes/No
Carry Inhaler? Carga Inhalador? Type _____	Yes/No	Hospitalizations?Hospitalizaciones? For What&When _____	Yes/No
Birth Defects? Defectos de Nacimiento? Specify _____	Yes/No	Surgery? Cirugia? For What & When _____	Yes/No
Developmental Delay?Retrasos del Desarrollo?	Yes/No	Serious Injury or Illness? Enfermedan o heridas serias?	Yes/No
Blood Disorders? _____ ProblemasDeLaSangre?	Yes/No	TB Skin Test Positive? Prueba positive dela piel para el TB?	Yes/No Yes/No
Diabetes?	Yes/No	Tobacco Use? Uso de Tabaco?	Yes/No
Head Injury/Concussion? Herida de la Cabeza?	Yes/No	Alcohol/DrugUse? Uso de Alcohool? Drogas?	Yes/No
Seizures? Convulsiones?_____	Yes/No	Family History of Sudden Death Before Age 50? Historial Familiar de Muerte repentina antes de los 50 anos?	Yes/No
Heart Problems/Short of Breath? Problemas Cardiacos/Falta de Respiracion?	Yes/No	Dental:Braces/Bridge/Plate? Ganchos/Puente/Placa?	Yes/No
Heart Murmur/High BP? Soplo Cardiaco/Presion Arterial Alta?	Yes/No	Dental: Other Otro?	Yes/No
Dizziness/Chest pain with Exercise? MareosO Dolor DePecho Al Hacer Ejercicio?	Yes/No	Medication Taken? Medicinas?	Yes/No
Bone/Joint Problems/Injury?Problemas de los huesos?	Yes/No	Allergies?Alergias?_____	Yes/No
Scoliosis? Escoliosis?	Yes/No	Any other Concerns?	Yes/No
Ear/Hearing Problems?Problemas de Audicion?	Yes/No	Otras Preocupaciones?	Yes/No
Eye/Vision Problems? Glasses/Contacts Last Exam Probemas de oyos/vista? Lentes/Contactos examen	Yes/No		

Health History Continued: Historial de Salud :

HealthCondition(s): Condiciones de salud;	**Additional comments: Cometarios adicionales**
Any medication taken at home? Medicinas tomadas en casa?	**No Yes: List**
Any medication taken at school? Medicianas tomadas en la escuela?	**No Yes-- List:**

By initialing below:

_____ I acknowledge that if the emergency care of my child involves medication, I will have a Medication at School Authorization form filled out by a physician and turned in to the school office on or before the first day of school.

Reconozco que si el cuidado de emergencia mi nijo/hija involucra medicamentos, yo he ilenadon una forma de Autorizacion Medica Escolar con la enfirmera de la escuela.

_____ I authorize the School District, and its employees and agents, to take the action they believe is appropriate in an emergency.

Autorizo al Distrito Escolar, y sus empleados y agente, para que tomen la accion que ellos crean apropiada en una emergencia.

_____ I agree to indemnify and hold harmless the School District, and its employees and agents, against any claims, except a claim based on willful and wanton conduct, arising out of the emergency care of my child.

Estoy de acuerdo de indemnificar y mantener sin dano al Distrib o Escolar, y sus empleados y agentes. Contra cualquer reclamo,.excepto un reclamo basado en conducta sin sentido, que surja a raiz del cuidado de emergencia de mi hijo/hija.

_____ I authorize this health information to be shared with appropriate school staff.

Autorizo que esta informacion de salud sea compartida con el personal escolar apropiado.

Does your child have school insurance? Yes No
Tiene asegaranza escolar su hijo/hija.? Si No
Is your child covered by other insurance? Yes No
Su hijo/hija tiene cubertura por otra azeguranza? Si No

If yes, identify the company and insurance number _____
Si tiene, identifiaue ala compania y numero de poliza_____

_____
Parent(s) / Guardian(s) Printed Name

_____ _____
Parent(s) / Guardian(s) Signature Date / Fecha

Oral Health Assessment Form

California law (*Education Code* Section 49452.8) states your child must have a dental check-up by May 31 of his/her first year in public school. A California licensed dental professional operating within his 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 he/she 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)

Child's First Name:	Last Name:	Middle Initial:	Child's birth date:
Address:			Apt.:
City:			ZIP code:
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 Hawaiian/Pacific Islander □ Unknown		

Section 2: Oral Health Data Collection (Filled out by a California licensed dental professional)

IMPORTANT NOTE: Consider each box separately. Mark each box.

Assessment Date:	Caries Experience (Visible decay and/or fillings present) □ Yes □ No	Visible Decay Present: □ Yes □ No	Treatment Urgency: □ No obvious problem found □ Early dental care recommended (caries without pain or infection; or child would benefit from sealants or further evaluation) □ Urgent care needed (pain, infection, swelling or soft tissue lesions)

_____ _____ _____

Licensed Dental Professional Signature ***CA License Number*** ***Date***

Section 3: Waiver of Oral Health Assessment Requirement

To 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 □ Healthy Families □ Healthy Kids □ Other _____ □ None

□ I cannot afford a dental check-up for my child.

□ I do not want my child to receive a dental check-up.

Optional: other reasons my child could not get a dental check-up: _____

If asking to be excused from this requirement: ▶_____

Signature of parent or guardian ***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 call your school.

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.

REPORT OF HEALTH EXAMINATION FOR SCHOOL ENTRY

To protect the health of children, California law requires a health examination on school entry. Please have this report filled out by a health examiner and return it to the school. The school will keep and maintain it as confidential information.

PART I TO BE FILLED OUT BY A PARENT OR GUARDIAN

CHILD'S NAME—Last	First	Middle	BIRTH DATE—Month/Day/Year

ADDRESS—Number, Street	City	ZIP code	SCHOOL

PART II TO BE FILLED OUT BY HEALTH EXAMINER

HEALTH EXAMINATION

NOTE: All tests and evaluations except the blood lead test must be done after the child is 4 years and 3 months of age.

REQUIRED TESTS/EVALUATIONS	DATE (mm/dd/yy)
Health History	_____/_____/_____
Physical Examination	_____/_____/_____
Dental Assessment	_____/_____/_____
Nutritional Assessment	_____/_____/_____
Developmental Assessment	_____/_____/_____
Vision Screening	_____/_____/_____
Audiometric (hearing) Screening	_____/_____/_____
TB Risk Assessment and Test, if indicated	_____/_____/_____
Blood Test (for anemia)	_____/_____/_____
Urine Test	_____/_____/_____
Blood Lead Test	_____/_____/_____
Other	_____/_____/_____

IMMUNIZATION RECORD

Note to Examiner: Please give the family a completed or updated yellow California Immunization Record.
Note to School: Please record immunization dates on the blue California School Immunization Record (PM 286).

VACCINE	DATE EACH DOSE WAS GIVEN				
	First	Second	Third	Fourth	Fifth
POLIO (OPV or IPV)					
DtaP/DTP/DT/Td (diphtheria, tetanus, and [acellular] pertussis) OR (tetanus and diphtheria only)					
MMR (measles, mumps, and rubella)					
HIB MENINGITIS (Haemophilus Influenzae B) (Required for child care/preschool only)					
HEPATITIS B					
VARICELLA (Chickenpox)					
OTHER (e.g., TB Test, if indicated)					
OTHER					

PART III ADDITIONAL INFORMATION FROM HEALTH EXAMINER *(optional)* *and* RELEASE OF HEALTH INFORMATION BY PARENT OR GUARDIAN

RESULTS AND RECOMMENDATIONS

Fill out if patient or guardian has signed the release of health information.

☐ Examination shows no condition of concern to school program activities.

☐ Conditions found in the examination or after further evaluation that are of importance to schooling or physical activity are: *(please explain)*

I give permission for the health examiner to share the additional information about the health check-up with the school as explained in Part III.

☐ Please check this box if you ***do not*** want the health examiner to fill out Part III.

Signature of parent or guardian — Date

Name, address, and telephone number of health examiner

Signature of health examiner — Date

If your child is unable to get the school health check-up, call the Child Health and Disability Prevention (CHDP) Program in your local health department. If you do not want your child to have a health check-up, you may sign the waiver form (PM 171 B) found at your child's school.

INFORME DEL EXAMEN DE SALUD PARA EL INGRESO A LA ESCUELA

Para proteger la salud de los niños, la ley de California exige que antes de ingresar a la escuela todos los niños tengan un examen médico de salud. Por favor, pidale al examinador de salud que llene este informe y entregelo a la escuela—este informe sera archivado por la escuela en forma confidencial.

PARTE I PARA SER LLENADO POR EL PADRE/LA MADRE O EL GUARDIÁN

NOMBRE DEL NIÑO/NIÑA—Apellido	Primer Nombre	Segundo Nombre	FECHA DE NACIMIENTO—Mes/Día/Año

DOMICILIO—Número y Calle	Ciudad	Zona Postal	Escuela

PARTE II PARA SER LLENADO POR EL EXAMINADOR DE SALUD

EXAMEN DE SALUD

AVISO: Todas las pruebas y evaluaciones excepto el análisis de sangre para el plomo deben ser hechas después de la edad de 4 años y 3 meses.

PRUEBAS Y EVALUACIONES REQUERIDAS	FECHA(mm/dd/aa)
Historia de Salud	_____/_____/_____
Examen Físico	_____/_____/_____
Evaluación de Dientes	_____/_____/_____
Evaluación de Nutrición	_____/_____/_____
Evaluación del Desarrollo	_____/_____/_____
Pruebas Visuales	_____/_____/_____
Pruebas con Audiómetro (auditivas)	_____/_____/_____
Evaluacion de Riesgo y prueba Tuberculosis*	_____/_____/_____
Análisis de Sangre (para anemia)	_____/_____/_____
Análisis de Orina	_____/_____/_____
Análisis de Sangre para el plomo	_____/_____/_____
Otra	_____/_____/_____

REGISTRO DE INMUNIZACIONES

Aviso al Examinador: Por favor dé a la familia, una vez completado, o a la fecha, el Registro de Inmunización de California en papel amarillo.
Aviso a la Escuela: Por favor apunte las fechas de inmunización sobre el Registro de Inmunización de la escuela de California en papel azul.

VACUNA	FECHA EN QUE CADA DOSIS FUE DADA				
	Primero	Segundo	Tercero	Quarto	Quinto
POLIO (OPV o IPV)					
DTaP/DTP/DT/Td (difteria, tétano y [acellular] pertusis [tos ferina]) O (tétano y difteria solamente)					
MMR (sarampión, paperas, rubéola)					
HIB MENINGITIS (Hemófilo, Tipo B) (Requerida para centros de cuidado para niños y centros preescolares solamente)					
HEPATITIS B					
VARICELLA (Viruelas locas)					
OTRA (e.g. prueba TB, de ser indicado)					
OTRA					

PARTE III INFORMACIÓN ADICIONAL DEL EXAMINADOR DE SALUD *(optional)* y PERMISO PARA DIVULGAR (DISTRIBUIR) EL INFORME DE SALUD

RESULTADOS Y RECOMENDACIONES

Llene esta parte si el padre/la madre o el guardián ha firmado el consentimiento para divulgar (distribuir) la información de salud de su niño/niña.

☐ El examen reveló que no hay condiciones que conciernen las actividades de los programas escolares.

☐ Las condiciones encontradas en el examen o después de una evaluación posterior que son de importancia para la actividad escolar o física son: (por favor explique)

***de ser indicado**

Yo le doy permiso al examinador de salud para que comparta con la escuela la información adicional de este examen como es explicado en la Parte III.

☐ Por favor marque esta caja si Ud. no desea que el examinador llene la Parte III.

Firma del padre/madre o guardián — Fecha

Firma del examinador de salud — Fecha

Si su niño o niña no puede obtener el examen de salud llame al Programa de Salud para la Prevención de Incapacidades de Niños y Jovenes (Child Health and Disability Prevention Program) en su departamento de salud local. Si Ud. no desea que su niño(a) tenga un examen de salud, puede firmar la orden (PM 171 B), formulario que se consigue en la escuela de su niño(a).

CHDP website: www.dhcs.ca.gov/services/chdp