**Sacramento City Unified School District**
**CHILD DEVELOPMENT DEPARTMENT – PRESCHOOL PROGRAMS**

Hi Doctor & Staff!

Our preschool programs follow the CHDP Periodicity Schedule and those that are HEAD START funded in particular, have some mandatory health reporting requirements. If they are not obtained the parent will be required to come to you again for this information.

All Physical Exam forms must be complete **and include**:

- the date(s) for the 2 yr. blood lead (*or more current*) and hemoglobin,
- complete Risk Assessment sections for TB and Lead,
- the height and weight,
- the results or record attempts for the sensory screenings(B/P, Hear & Vision),
- and please make sure the immunizations are complete and up to date

Thank you very much!

**Sacramento City Unified School District - Child Development Department**

**Fax: Hiram Johnson: (916) 277-6698**

# Preschool Physical Examination

**Child's Name:** _____ **Birth Date:** _____ **Preschool:** _____

Parent's/Guardian's Authorization: I hereby give my consent to Child Development Department representative and my physician to exchange health information concerning my child.

**Parent/Guardian Signature:** _____ **Date:** _____

**Required (Note: Incomplete or blanks in this section will be returned to Physician to complete)**

Date: _____ Hemoglobin/Hematocrit: _____ At Risk for Anemia? Yes ☐ No ☐ Receiving Tx? Yes ☐ No ☐

Date: _____ Blood Lead: _____ug/dl At Risk for Lead Poisoning? Yes ☐ No ☐ Receiving F/u? Yes ☐ No ☐

Date: _____ TB Risk Assessment Given by Provider: Yes ☐ No ☐ Child has TB Risk? Yes ☐ No ☐

If Yes, PPD Date Given:_____ Date Read:_____ Results:_____

**Required (Starting at Age 3)**

Date: _____ Blood Pressure:_____

Date: _____ Hearing: (*25db @1000,2000,&4000*) **R:** ☐ Pass ☐ Fail **L:** ☐ Pass ☐ Fail

Date: _____ Vision: **R:** 20/____ ☐ Pass ☐ Fail **L:** 20/____ ☐ Pass ☐ Fail

Visual Acuity Concerns? ☐ No ☐ Yes, If yes, referred? ☐ Yes ☐ No Name of Specialist _____

Hearing Acuity Concerns? ☐ No ☐ Yes, If yes, referred? ☐ Yes ☐ No Name of Specialist _____

| **Date of Physical Exam:** | **HEIGHT:** **IN** | **WEIGHT:** **LBS** |
|---|---|---|

| Examination Results | Normal | Abnormal | Describe Findings / Comments |
|---|---|---|---|
| **General Appearance** | | | |
| **Head, Ears, Eyes, Nose & Throat** | | | |
| **Teeth / Gums** | | | |
| **Heart / Lung** | | | |
| **Abdomen / Genitourinary** | | | |
| **Extremities / Skeletal** | | | |
| **Posture and Gait** | | | |
| **Neurological (Fine, Gross Motor)** | | | |
| **Speech** | | | |
| **Skin** | | | |
| **Developmental Status** | | | |

**Health Concerns / Diagnoses:**

**Food Allergy: ☐ No ☐ Yes List** _____

**Lactose Intolerance: ☐ No ☐ Yes List** _____

**Other Severe Allergy ( e.g. Latex, beesting, scents): List** _____

**Medications Taken at Home? ☐ No ☐ Yes, List:** _____

**Medications Required at School? ☐ No ☐ Yes, List:** _____

**Physical Activity: ☐ No Restrictions ☐ Limited, Explain:** _____

**Special Education Services? ☐ No ☐ Yes Active IEP? ☐ No ☐ Yes**

**Dental Referral: ☐ No ☐ Yes; Dental Varnish Given: ☐ No ☐ Yes; NaFl Given: ☐ No ☐ Yes**

**Nutrition Counseling Given: ☐ No ☐ Yes Nutrition Counseling Referral: ☐ No ☐ Yes**

**Physician's Name (PRINT)** _____ **Physician's Signature** _____

**Medical Group Name** _____ **Phone: (____)** _____ **Fax: (____)** _____

**Street Address** _____ **City:** _____ **State:** _____ **Zip:** _____