McGill School of Success

3025 Fir Street, San Diego, CA 92102
619-629-0770b 619-239-1318f

Health Assessment Record

Report of Health Checkup for School Entry

California law requires a health checkup for school entry to protect the health of all children.
Please return this report to the school. All information will be keep confidential

Name of Student (Last, First, Middle)	**Birth Date**	**Sex**

Address (Street)	**Race/Ethnicity**	
	□ Black, not of Hispanic origin	□ White, not of Hispanic orgin
	□ Asian	□ Hispanic/Latino
	□ America Indian	□ Other

Home Telephone Number:	**School Name:**	**Grade:**

Parent/Guardian Name: (Last, First, Middle)

Health Care Provider	**Health Insurance Company/Number or Medicaid Number**

Part I - To be completed by parent

Important: Complete Part I before your child is examined
Take this form with you to the health care provider's office.

Please check answers to the following questions in columns on the left.
(Explain all ":yes:" in the space provider's office.

	Yes	No	
1.	□	□	Do you have any concerns about your child's general health (overall eating and sleeping habits, teeth, etc.)?
2.	□	□	Has your child been diagnosed with any chronic disease? □ asthma □ diabetes □ seizure disorder □ other _____
3.	□	□	Does your child have any allergies (food, insects, medication, latex, etc.)?
4.	□	□	Does your child take any medications (daily or occasionally)?
5.	□	□	Does your child have any problems with vision, hearing or speech (glasses contacts, ear tubes, hearing aids)?
6.	□	□	Has your child had any hospitalization, operation, major illness or injury, or significant accident? (Please specify)
7.	□	□	In the last 12 months, has your child experienced any difficulty with wheezing, excessive coughing or excessive night waking? (Please specify.)_____
8.	□	□	In the last 12 months, has your child experienced any difficulty with excessive weight loss or weight gain, or excessive thirst or urination? (Please specify.)
9.	□	□	Does your child have health insurance?
10.	□	□	Does your child have dental insurance?
11.	□	□	Would you like to discuss anything about your child's health with school nurse?

Please explain any ":yes:" answers here. For illnesses/injuries/etc., include the year and/or your child's age at the time

_____

_____

_____

I give permission for release of information on this form for confidential use in meeting my child's health and education needs in school

_____ _____
Signature of Parent/Guardian Date

To be maintained in the student's Cumulative School Health Record

McGILL SCHOOL of SUCCESS
Planting the Seeds of Knowledge

Part II - Medical Evaluation

To the Health Care Provider: Please complete and sign.

_____ had a complete history and physical exam on _____

Student's Name Birthdate

Note: Mandated Screening/Testing under California Law

Findings for this student are as follows:

Screening/Test Results

Height:		BMI:
Weight:		Postural
Blood Pressure:		☐ Normal
Pulse:		☐ Abnormal
HCT/HGB:		Min. _____
Urinalysis:		Slight _____
Gross Dental:		Mod. _____
Lead (Date Result)		Marked _____
		☐ Referral

TB and Other Test Results (Sickle Cell, etc.)

TB: In high-risk group? ☐ Yes ☐ No

Test	Date	Results

Vision Type of Screening	Auditory/Type of Screening
With glasses R R 201 201	Pass/Fail R
Without glasses R L 201 201	L

Chronic Disease Assessment:

No Yes Date of onset

☐ ☐ Asthma ☐ mild ☐ moderate ☐ severe _____

☐ ☐ exercise induced ☐ unclassified _____

☐ ☐ Diabetes ☐ Type I ☐ Type II _____

☐ ☐ Anaphylactic Reaction ☐ food ☐ insect ☐ latex _____

☐ ☐ Seizure Disorder _____

☐ ☐ Other: Please specify _____

Immunization Record

To be completed by the Health Provider

(Must be completed in full to meet California law)

Other Health Information (Optional)

For the child's welfare-and with the parent's permission – It is recommended that significant health information be shared with the school. If the child needs help with medication. At school, please contact the school nurse.

- ☐ The checkup reveals no conditions of importance to the school or physical activity.
- ☐ Conditions that need further evaluation or that can affect school or physical activity are: (please explain)

Explain: _____

Medical Provider Information

Name, Address, and Telephone Number:

_____ _____

Signature of Medical Professional **Date**

This student has the following problems which may adversely affect his or her education experience: **(Please check box)**

☐ Vision ☐ Auditory ☐ Speech/Language ☐ Physical Dysfunction ☐ Emotional ☐ Behavior

The pupil has a health condition which may require emergency action at school, e.g., seizures, allergies, anaphylaxis. ***Specify below.***

The pupil is on long-term medication. ***Specify below.***

Comments and recommendations (additional information about any of the above health assessment): _____

☐This student may participate fully in the school program, including physical education activities.☐☐

☐This student may participate in the school program and physical education with the following restriction/adaption .

(Specify reason and restriction) _____

☐ Yes ☐ No Based on this comprehensive health history and physical examination, this student has maintained his/her level of well.

☐ I would like to discuss information in this report with the school nurse.