KENTUCKY DEPARTMENT OF EDUCATION
MEDICAL EXAMINATION OF SCHOOL EMPLOYEES*

Name _____ **Date of Birth** ____/____/____ **Sex: M** ☐ **F** ☐

Address _____ **Telephone** _____

Applicant With or Employed By _____ **Board of Education**

HISTORY

Medical (All serious medical and psychiatric diseases: diabetes, epilepsy, heart disease, etc.) _____

_____

_____

_____

Surgical (All major operations) _____

_____

"Per the Genetic Information Nondiscrimination Act of 2008, it is unlawful for an employer to request genetic information, genetic testing information, family medical history information, or family genetic testing information from an applicant or employee. The medical provider conducting this examination of an applicant/employee of a local school district shall not request, require or purchase this information about the applicant or employee. Any applicant or employee undergoing a medical examination for employment with a local school district shall not provide this information to the medical provider or the school district."

PHYSICAL

1. General Appearance _____
2. Eyes _____
3. Ears, Nose & Throat _____
4. Teeth & Gums _____
5. Thyroid _____
6. Heart _____
7. Blood Pressure _____ Pulse _____
8. Lungs _____
9. Abdomen _____
10. Nervous System _____
11. Extremities _____

Other _____

Tuberculosis Risk Factor Assessment

Yes ☐ No ☐ High risk for Tuberculosis infection

Yes ☐ No ☐ Referred to local health department for further TB infection evaluation

Yes ☐ No ☐ Tuberculosis test performed (specify: _____TST/_____BAMT)

_____Date of chest X-Ray

☐ No further follow-up unless signs/symptoms of Tuberculosis infection develop

I have examined _____ and find him/her free of communicable disease and any physical or mental disabilities that might interfere with performing his/her duties, except as follows:

_____

_____

_____

_____ _____

Date of Examination Signature (Physician/PA/APRN)

* School Bus Drivers are required to use form TC94-35E.

PREVENTIVE STUDENT HEALTH CARE EXAMINATION FORM

All local boards of education shall require a preventive health care examination of each child first entering a Kentucky public school within a period of twelve (12) months prior to initial admission to school and within one (1) year prior to entry to sixth grade. Local school boards may extend this time not to exceed two (2) months. (702 KAR 1:160)

PLEASE COMPLETE THE IDENTIFYING INFORMATION AND RECORDS

IDENTIFYING INFORMATION

Student Name: _____ **Gender:** **M** **F** **Grade:** _____

Date of Birth: _____ **Age:** _____ **yrs** _____ **months** **Preferred Language:** _____

Parent or Guardian Name: _____

RECORD OF IMMUNIZATIONS TO BE REPORTED ON IMMUNIZATION CERTIFICATE FORM, EPID 230.

MEDICAL HISTORY

Allergies: _____

Current Prescribed Medications to be taken daily at school: _____

Significant Historical Information: _____

SCREENING RESULTS:

BP: _____ **Height:** _____ **(ft.)** _____ **(inches)** **Weight** _____**lbs.** **BMI**_____ **BMI%**_____

Vision	**Right 20/**_____	**Passed** ☐ **Failed** ☐ **Referred** ☐	**Hearing – Right**	**Passed** ☐	**Failed** ☐	**Referred** ☐
	Left 20/_____		**Hearing - Left**	**Passed** ☐	**Failed** ☐	**Referred** ☐

Optional: **Hct/HGB:** _____ **Lead:** _____ **Urinalysis:** _____

General appearance	☐ **Normal**	☐ **Abnormal** _____	**Refer/Tx:** _____
Gross dental (teeth and gums)	☐ **Normal**	☐ **Abnormal** _____	**Refer/Tx:** _____
Head/scalp/skin	☐ **Normal**	☐ **Abnormal** _____	**Refer/Tx:** _____
Eyes/Ears/Nose/Throat	☐ **Normal**	☐ **Abnormal** _____	**Refer/Tx:** _____
Chest/Lungs/Heart	☐ **Normal**	☐ **Abnormal** _____	**Refer/Tx:** _____
Abdomen/Genitalia	☐ **Normal**	☐ **Abnormal** _____	**Refer/Tx:** _____
Extremities/back	☐ **Normal**	☐ **Abnormal** _____	**Refer/Tx:** _____
Neuro	☐ **Normal**	☐ **Abnormal** _____	**Refer/Tx:** _____

This child has the following problems that may impact the educational 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 restriction/adaptation.**

(Specify reason and restriction) _____

_____

ANTICIPATORY GUIDELINES

Discussed and/or handout given

☐ **SCHOOL READINESS**
- **Establish routines**
- **After-school care/activities**
- **Friends**
- **Bullying**
- **Communicate with teachers**

☐ **MENTAL HEALTH**
- **Family time**
- **Anger management**
- **Discipline for teaching not punishment**
- **Limit TV, computer**

☐ **NUTRITION AND PHYSICAL ACTIVITY**
- **Healthy weight**
- **Well-balanced diet, including breakfast**
- **Fruits, vegetables, whole grains, dairy**
- **60 minutes of exercise/day**

☐ **ORAL HEALTH**
- **Regular dentist visits**
- **Brushing/Flossing**
- **Fluoride**

☐ **SAFETY**
- **Sexual safety**
- **Pedestrian safety**
- **Safety helmets**
- **Swimming safety**
- **Fire escape plan**
- **Smoke/carbon monoxide detectors**
- **Guns**
- **Sun**
- **Appropriately restrained in all vehicles**

Additional comments or recommendations: _____

_____

_____

_____

_____

_____

Signed: _____ **Date:** _____

Physician/APRN/PA/EPSDT Provider

Address: _____ **Telephone:** _____

Name _____ Date of Birth _____ Physical Examination(s) _____

(*Last)* *(First)* *(Middle)*

Health conditions such as severe allergies, disabilities, chronic illness, or other special health needs (add comments on back): _____

_____

504/IEP Date of Review or Reevaluation _____

Screening Record

Record the date of screening and student's age with each screening result. *Indicate with an asterisk if student is wearing glasses during vision screening.

DATE	(age)	(age)	(age)	(age)	(age)	(age)	(age)	(age)	(age)
Height									
Weight									
BMI Percentile									
Vision: Right Eye									
Left Eye									
Hearing: Right Ear									
Left Ear									

DOCUMENTATION

Use this side to record referrals and follow-ups *(physician, clinic, parent, etc.)*, special procedures required during the school day, or other significant findings that may affect the student's school participation. Please sign and date all entries.

PUPIL'S CUMULATIVE HEALTH RECORD

The purpose of this record is to give the health professional a concise summary of the student's school health history. It is not intended to be used for daily documentation. Parent and emergency information should be maintained elsewhere.

Screenings are recorded by date and student age rather than grade level. This accommodates changes in the primary program and documents information more accurately for the student.

KDE/DSS **Kentucky Eye Examination Form for School Entry** **KDESHS004**

KRS 156.160 (1) (i) requires proof of a vision examination by an optometrist or ophthalmologist. This evidence shall be submitted to the school no later than January 1 of the first year that a three (3), four (4), five (5) or six (6) year old child is enrolled in public school, public preschool, or Head Start program.

PLEASE COMPLETE THE IDENTIFYING INFORMATION

Date of student's enrollment: _____ **Date of Vision Examination:** _____

IDENTIFYING INFORMATION

Student Name: _____

Date of Birth: _____

Parent or Guardian Name: _____

CASE HISTORY

Date of Exam: _____

Ocular History: Normal or Positive for: _____

Medical History: Normal or Positive for: _____

Drug Allergies: NKDA or Allergic to: _____

Family Ocular and Medical History: ☐ Amblyopia ☐ Strabismus ☐ Glaucoma ☐ Diabetes

Other: _____ _____

Other Pertinent Information: _____

Refraction with cycloplegic? (Please indicate one.) ☐ YES ☐ NO

	OD	OS
Unaided Acuity	20/	20/
Best Corrected Acuity	20/	20/

Type of Examination	Normal	Abnormal	Notable to Assess
External Exam (eye and adnexa)			
Internal Exam (media, lens, fundus, etc)			
Neurological Integrity (pupils)			
Binocular Function (stereopsis)			
Accommodation and convergence			
Color Vision			

Diagnosis:

☐ Normal ☐ Myopia ☐ Hyperopia ☐ Astigmatism ☐ Strabismus ☐ Amblyopia

Other: _____

Recommendations:

1 Glasses prescribed: ☐ YES ☐ NO
2 _____
3 _____

Age appropriate and suggested anticipatory guidance (health assessments):

- ☐ Educate (parents/patients) about eye/vision disorders and needed vision care
- ☐ Counsel (parents/patients) regarding eye safety
- ☐ Stress importance of early, preventative eye care
- ☐ Recommend re-examination, as appropriate

Signed: _____ Date: _____
Optometrist/Ophthalmologist

Address: _____ Telephone: ( ) _____

OAS/DSS **Kentucky Dental Screening/Examination Form for School Entry** **KDESHS005**

Kentucky law, KRS 156.160(j), requires proof of a dental screening or examination by a dentist, dental hygienist, physician, registered nurse, advanced practice registered nurse, or physician assistant. This evidence shall be presented to the school no later than January 1 of the first year that a five (5) or six (6) year old is enrolled in public school.

Student Name: _____
Last First Middle

Birth date: _____/_____/_____ Gender: ☐ 0 Male ☐ 1 Female

Parent or Guardian:_____
Name Relationship

Address:_____ City: _____

Phone Number:_____ School:_____

Date of Exam/Screening _____/_____/_____

Test Type (check one)

☐ Screening

☐ Exam

Screener's Name: _____

Screener's Address: _____

_____

Phone Number:_____Screening Date:_____

Screener's Signature:_____

Professional affiliation: (Please check one)

☐ Dentist ☐ Dental Hygienist

☐ Physician Assistant ☐ *Registered Nurse

☐ APRN ☐ Physician

Untreated Decay: (Check one)

☐ 0 No untreated cavities

☐ 1 Untreated cavities

Treated Decay: (Check one)

☐ 0 No treated cavities

☐ 1 Treated cavities

Pattern of Early Childhood Cavities: (Check one)

☐ 0 No Early Childhood Cavities

☐ 1 Early Childhood Cavities Present

Treatment Urgency: (Check one)

☐ 0 No obvious problem

☐ 1 Early dental care needed

☐ 2 Referral for Urgent Care
NOTE: Comment required if marked.

Comments:

***Note: It is the RNs responsibility to consult the KBN Scope of Practice before conducting screenings.**