El Dorado Public Schools

Administrative Offices • 200 West Oak • El Dorado, Arkansas 71730

Keeping the Promise

Teaching and Learning for All

Dear Parent:

We welcome your kindergarten child to El Dorado Schools this fall and are anxious to help every student get off to a good start in his/her education year. Starting in 1994-95 all Arkansas school districts have had to participate in health screening to ensure that each student has no health problems that might impede his/her progress in school. This means every kindergarten student in the El Dorado School District must have a health screening.

We are asking that parents try to complete this screening prior to the beginning of school. Attached are two (2) forms. One is a **Health History** to completed by the parent prior to the screening. The other is a **Physical Assessment** to be completed by a private physician.

If your kindergarten child has had a physical examination within the last year, a note from your physician to that effect will suffice. You may give these completed forms to your child's teacher on the first day of school.

We appreciate your cooperation and support in our efforts to give your child every opportunity for success in school. If you have any questions, please call my office at 870-864-5006.

Sincerely,

Jim Tucker
Superintendent of schools

Enclosures (2)

NOTE: To be completed by parent prior to physical examination/nursing assessment.

Health History

FOR KINDERGARTEN AND/OR FIRST GRADE STUDENTS

Student Name (Last, First, Middle)	Birth Date (Mo./Day/Year) / /	School	Medicaid Number
First Parent/Guardian Name		Phone 1	Phone 2
Second Parent/Guardian Name		Phone 1	Phone 2
Physician Name and Address (If no regular physician, write "None")			Phone
Dentist Name and Address (If no regular dentist, write "None")			Phone

Other source(s) from which the student receives health care, and name of Health Insurance Company. (If none, write "None")

To be completed by parent:

1. Does your child pay attention when being read to?	Yes	No
2. Can your child play quietly alone for over 1/2 hour?	Yes	No
3. Does your child mind adults and follow instructions?	Yes	No
4. Does your child speak clearly enough for others to understand?	Yes	No
5. Does your child have any speech problems stammering, delayed speech development, etc.?	Yes	No
6. Does your child object to being left with a sitter?	Yes	No
7. Can your child dress without help?	Yes	No
8. Does your child ever wet or soil him/herself during the day?	Yes	No
9. Do you have any concerns about your child's general health (eating and sleeping habits, bowel or bladder, posture, teeth, skin, weight, etc.?)	Yes	No

	Yes	No
10. Does your child have any eye problems (difficulty seeing, crossed eyes, frequently reddened or watery eyes, wear glasses or contact lenses)?	Yes	No
11. Does your child have any ear or hearing problems (frequent earaches, difficulty hearing, draining ear, use a hearing aid, etc.)?	Yes	No
12. Does your child have any allergies (foods, insects, drugs, pollens, etc.)?	Yes	No
13. Does your child have any specific sickness which might, in your opinion, affect his school performance or progress?	Yes	No
(A) Has your child received any medical or other evaluation, the findings of which could help school personnel in meeting his health or educational needs?	Yes	No
(B) Does this problem require any health care in the school?	Yes	No
(C) Does your child take medication?	Yes	No
14. Do you have any concerns about your child's developmental behavior or emotional well-being of which the school should be aware?	Yes	No

If you answered yes to any of the preceding questions please describe the problem or concern you have.

<u>Question Number</u> <u>Description</u>

Information on this form may be shared with appropriate personnel for health and educational purposes.

Parents Signature: ______________________________ Date: ____________

Name______ Race______ Sex______

ID Number______ Birthdate______ (Month/Day/Year)

Parent or Guardian______

PHYSICAL ASSESSMENT

To Be Completed by Physician, Nurse, School Health Professional, or Child Care Professional

REQUIRED

	NL	ABNL	Comments
BP: WT: HT:			
SKIN: Color, Rash, Swelling, Hair, Nails			
EYES: Conjunctiva, Cornea, Pupils, Extraocular Movement			
EARS: Pinnae, Canals; Tympanic Membrane Appearance, Mobility			
NOSE: Nares, Turbinates			
MOUTH: Tongue, Teeth, Oral Mucosa, Tonsils, Pharynx			
NECK: Thyroid, Range of Motion			
NODES: Cervical, Axillary, Inguinal, Other			
HEART: Rate, Rhythm, S1, S2, Murmur, Femoral Pulses			
LUNGS: Rate, Auscultation, Percussion			
ABDOMEN: Contour, Palpation of Liver, Spleen, Kidney; Mass; Tenderness			
GENITO-URINARY: Female External, Male Penis, Meatus, Testes, Hernia			
MUSCULOSKELETAL: Range of Motion, Tenderness, Edema, Clubbing, Spine (Curvature)			
NEUROLOGICAL: Gait, Cerebellar Function, Motor System (Strength, Tone); Cranial Nerves (Gross)			
DEVELOPMENTAL:			
Gross Motor			
Fine Motor			
Social			
Speech/Language			

LABORATORY (as indicated)

	Date	NL	Comments
Hemoglobin			
Hematocrit			
Urinalysis			
Other			

Medications ______

Diet Restrictions ______

Special Equipment ______

Allergies ______

General Comments/Recommendations ______

I have performed a physical assessment on this child on the date indicated, and have arranged for any follow-up that was or is needed.

Signature______ (Physician, Nurse, School Health Professional, or Child Care Professional) Phone______ Date Signed______ Date of Exam______