Members of the Board
Beth Albiani
Nancy Chaires Espinoza
Carmine S. Forcina
Gina Jamerson
Michael Vargas
Anthony "Tony" Perez
Sean J. Yang

Dr. Tabitha E. Thompson, LCSW
Director, PreK-6 Education

(916) 686-7704
FAX: (916) 686-7796
Email: tethomps@egusd.net

Robert L. Trigg Education Center
9510 Elk Grove-Florin Road, Elk Grove, CA 95624

Estimado proveedor de atención médica: (Por favor complete los formularios de salud porpocionados por la programa de preescolar en E.G.U.S.D.)

Los niños que están inscritos en el programa de preescolar en el Distrito Escolar Unificado de Elk Grove (EGUSD) deben cumplir con los requisitos de licencia establecidos por el Departamento de Educación de California.

Estos requisitos incluyen tener un examen físico / dental realizado por, o bajo la supervisión de, un médico/dentista con licencia y **debe completarse dentro 30 dias en el que el niño/a es inscrito/a en el programa.**

Los requisitos de licencia establecen que el examen físico **debe incluir**:

- Altura
- Peso
- Presión sanguínea
- Hematocrito o Hemoglobina (Prueba de sangre para verificar la anemia)
- Evaluación de riesgo de tuberculosis o pantalla detuberculosis
- Pantalla de visión
- Pantalla de audición
- Pantalla de plomo (18 meses)

Para evitar que el niño/a posiblemente no sea admitido en nuestro programa debido a que el examen físico no está completo, le solicitamos que haga una prueba para todo lo mencionado anteriormente.

Se debe completar un examen dental. Si se requiere tratamiento adicional, proporcione lasfechas de citas.

Estimado Padre / Guardián,

Revise los formularios de examen físico / dental para asegurarse de que se hayan completado todos los artículos **antes** de salir de la oficina del medico. El examen físico y/o dental complete se puede devolver a la oficina preescolar designada o por correo electrónico.

Elk Grove Unified School DistrictPreK-6 Education

PRESCHOOL PHYSICAL EXAMINATION

Child's Name:_____ **Birth Date:**_____ ☐ **M** ☐ **F**

Parent/Guardian Name:_____ **Phone:** _____

Parent's/Guardian Authorization: I hereby give my consent to an Elk Grove Unified District 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☐

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			

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 _____

Health Concerns / Diagnoses:

Food Allergy: ☐ No ☐ Yes List ____

Lactose Intolerance: ☐ No ☐ Yes

List __ **Other Severe Allergy (e.g. Latex, bee sting, 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:_____ **Signature:**_____ **Date:** _____

Address:_____ **Phone:**_____ **Fax:** _____

PRESCHOOL OFFICE USE ONLY	*Date received by PreK office*	*Date Received by classroom*	*Date entered into Child Plus*	*Date Event closed in Child Plus*

Elk Grove Unified School District
PreK-6 Education

PRESCHOOL DENTAL HEALTH / EXAM RECORD

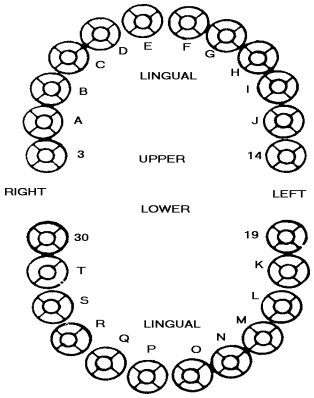
Child's Name:_____ Birth Date:_____ ☐M ☐F

Parent/Guardian Name:_____ Phone: _____

Parent/Guardian Authorizations: I hereby give my consent to EGUSD PreK-6 Education and my physician to exchange health information concerning my child.

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

DENTAL PROVIDER:



PLEASE LIST ALL SERVICES PROVIDED BELOW AND COMPLETE SUMMARY

Date of Service	Tooth # or Letter	Description of Services Provided

In the diagram to the left, indicate oral conditions before treatment: Missing Decayed Filled

CHILD ORAL HEALTH SUMMARY *(check one or more)*

Date of Cleaning and Fluoride treatment: _____

☐ No Treatment Needed ☐ Dental Treatment Received ☐ Preventative Care Given

☐ Needs Treatment:

☐ Specialist Referral given: _____

☐ Approx. # of visits needed:_____ Next Appointment Date: _____

Comments: _____

Dentist Name (Print):_____Signature:_____Date:_____

Address:_____Phone:_____Fax: _____

**** IF TREATMENT IS NOT COMPLETE, PLEASE FILL OUT A NEW FORM FOR EACH ADDITIONAL VISIT UNTIL TREATMENT IS COMPLETE.***

Revised 12/12/19

PRESCHOOL OFFICE USE ONLY	*Date received by PreK office*	*Date Received by classroom*	*Date entered into Child Plus*	*Date Event closed in Child Plus*