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Dear Health Care Provider:

Children who are enrolled in preschool in Elk Grove Unified School District (EGUSD) must meet the licensing requirements set forth by the California Department of Education.

These requirements include having a physical/dental exam performed by, or under the supervision of, licensed physician/dentist and **must be completed within 30 days of entry into the program.**

Licensing requirements state that **the physical examination must include:**

- Height
- Weight
- Blood Pressure
- Hematocrit or Hemoglobin (Blood count for anemia)
- Tuberculosis Risk Assessment or Tuberculosis Screen
- Vision Screen
- Hearing Screen
- Lead Screen (18 months)

To avoid the possibility of the child not being admitted into our program due to an incomplete physical, we request that you screen for all of the requirements listed above.

A dental examination must be completed. If additional treatment is required, please provide the appointment dates.

Dear Parent/Guardian,

Please review the physical/dental exam forms to make sure all of the items have been completed **before** leaving the doctor's office.

Revised 8/20/21

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

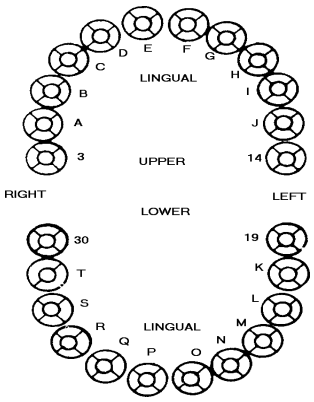
Child's Name:_____ Birth Date:_____ ☐M ☐F

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

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