SD USD San Diego Unified School District

EARLY CHILDHOOD EDUCATION PROGRAMS

Child's Health Record

CDC Center: State Preschool/School Readiness: AM PM Full Day

Student's Name: (Last) (First) (Middle) ☐ M ☐ F

Parents' Names: (Last) (First) (Last) (First)

Telephone: ______________________ Student's Date of Birth: ______________________

Persons to be contacted in case of emergency (name/phone):

CHILD'S HEALTH HISTORY: TO BE COMPLETED BY PARENT/GUARDIAN

Allergy: ☐ Y ☐ N

Allergic to: ______________________

Reaction: ______________________

Asthma: ☐ Y ☐ N

Meds: ______________________

Diabetes: ☐ Y ☐ N

Seizure Disorder: ☐ Y ☐ N

Heart problems: ☐ Y ☐ N

Chronic disease: ☐ Y ☐ N

Ear problem/Hearing Defect: ☐ Y ☐ N

Frequent ear infections: ☐ Y ☐ N

Eye problem: ☐ Y ☐ N

Glasses: ☐ Y ☐ N

Medications: ☐ Y ☐ N List: ______________________

Previous Operations/Hospitalizations: ☐ Y ☐ N Reason: ______________________

(I), (WE), the undersigned parent/guardian of ______________________, do hereby authorize employees of the San Diego Unified School District to obtain **emergency medical treatment** as prescribed and deemed necessary. This authorization is given pursuant to the provision of Section 25.8 of the Civil Code of California and is given in advance of any specific diagnosis, treatment or hospital care being required.

Parent/Guardian Signature ______________________ Date ______________________

PHYSICAL: TO BE COMPLETED BY PHYSICIAN

HT: ________ WT: ________ B/P: ________ TEMP: ________ HEART RATE: ________ RESP: ________

TB Exposure: ☐ Y ☐ N Tobacco Exposure: ☐ Y ☐ N Lead blood test (if at risk): ☐ Y ☐ N

High Risk Factors: ☐ Y ☐ N Hemoglobin: ______________________ Lead blood test Lab Results: ________

Sickle Cell: ☐ Y ☐ N Urinalysis: ______________________ Other: ______________________

IMMUNIZATIONS REQUIRED FOR PRESCHOOL: 3-Polio 4-DPT 1-MMR & 1-HIB (after 1st birthday)
1-Varivax (after 1st birthday) or MD verified Chicken Pox Disease 3-Hepatitis B – Series must be started

PHYSICAL EXAMINATION

	WNL	ABN			WNL	ABN	
General Appearance	☐	☐		Lungs	☐	☐	
Head	☐	☐		Abdomen	☐	☐	
Eyes	☐	☐	**Vision:**	Genitalia, Male	☐	☐	
Ears	☐	☐	**Hearing:**	Female	☐	☐	
Nose	☐	☐		Hips	☐	☐	
Mouth & Pharynx	☐	☐		Fine Motor	☐	☐	
Dental	☐	☐		Gross Motor	☐	☐	
Neck	☐	☐		Skin	☐	☐	
Spine	☐	☐		Neuro	☐	☐	
Heart	☐	☐		Speech	☐	☐	
Glands	☐	☐					

ALLERGIES

Food: ☐ Y ☐ N List: ______________________

Insect stings: ☐ Y ☐ N List: ______________________

Medicines: ☐ Y ☐ N List: ______________________

ASTHMA ☐ Y ☐ N

Inhaler needed: ☐ Y ☐ N

Are medications needed at school? ☐ Y ☐ N

List: ______________________

Other: ☐ Y ☐ N List: ______________________

EPI Pen needed: ☐ Y ☐ N

Recommendations: ______________________

Referrals: ______________________

PHYSICIAN'S NAME/STAMP: ______________________

PHYSICIAN'S SIGNATURE: ______________________ **PHONE:** ____________ **DATE:** ________

SG:sh 2/10/09

San Diego Unified School District

PROGRAMAS DE EDUCACIÓN DE PRIMERA INFANCIA

Documentación de la Salud del Niño

Centro de CDC: Preescolar estatal/Preparación escolar: AM PM Día completo

Nombre del alumno: (Apellido) (Nombre) (Segundo) ☐ M ☐ F

Nombres de los padres: (Apellido) (Nombre) (Apellido) (Nombre)

Teléfono: ____________ Fecha de nacimiento del alumno: ____________

Personas de contacto en caso de emergencias:

HISTORIAL DE SALUD DEL NIÑO: DEBE SER COMPLETADA POR EL PADRE/TUTOR

Alergia: ☐ S ☐ N | Diabetes: ☐ S ☐ N | Problemas del oído/ Defecto auditivo: ☐ S ☐ N

Alérgico a: ____________ | Trastorno convulsivo: ☐ S ☐ N | Infecciones frecuentes del oído: ☐ S ☐ N

Reacción: ____________ | Problemas del corazón: ☐ S ☐ N | Problemas de los ojos: ☐ S ☐ N

Asma: ☐ S ☐ N | Enfermedad crónica: ☐ S ☐ N | Lentes: ☐ S ☐ N

Medicinas: ____________

Medicamentos: ☐ S ☐ N Lista: ____________

Operaciones/Hospitalizaciones Previas: ☐ S ☐ N Razón:

(Yo), (Nosotros), el padre/tutor infrascrito de ____________, autorizo por medio de la presente que los empleados del Distrito Escolar Unificado de San Diego obtengan **tratamiento médico de emergencia** como sea recetado y considerado necesario. Se otorga esta autorización según lo acordado en la provisión de la Sección 25.8 del Código Civil de California, y se da antes de que se requiera diagnosis, tratamiento u hospital específico.

Firma del padre/tutor ____________ Fecha ____________

PHYSICAL: TO BE COMPLETED BY PHYSICIAN

HT: ______ WT: ______ B/P: ______ TEMP: ______ HEART RATE: ______ RESP: ______

TB Exposure: ☐ Y ☐ N Tobacco Exposure: ☐ Y ☐ N Lead blood test (if at risk): ☐ Y ☐ N

High Risk Factors: ☐ Y ☐ N Hemoglobin: ______ Lead blood test Lab Results: ______

Sickle Cell: ☐ Y ☐ N Urinalysis: ______ Other: ______

IMMUNIZATIONS REQUIRED FOR PRESCHOOL: 3-Polio 4-DPT 1-MMR & 1-HIB (after 1st birthday)

1-Varivax (after 1st birthday) or MD verified Chicken Pox Disease 3-Hepatitis B – Series must be started

PHYSICAL EXAMINATION

	WNL	ABN			WNL	ABN	
General Appearance	☐	☐		Lungs	☐	☐	
Head	☐	☐		Abdomen	☐	☐	
Eyes	☐	☐	**Vision:**	Genitalia, Male	☐	☐	
Ears	☐	☐	**Hearing:**	Female	☐	☐	
Nose	☐	☐		Hips	☐	☐	
Mouth & Pharynx	☐	☐		Fine Motor	☐	☐	
Dental	☐	☐		Gross Motor	☐	☐	
Neck	☐	☐		Skin	☐	☐	
Spine	☐	☐		Neuro	☐	☐	
Heart	☐	☐		Speech	☐	☐	
Glands	☐	☐					

ALLERGIES ______ Are medications needed at school? ☐ Y ☐ N

Food: ☐ Y ☐ N List: ______ List: ______

Insect stings: ☐ Y ☐ N List: ______ Other: ☐ Y ☐ N List: ______

Medicines: ☐ Y ☐ N List: ______ EPI Pen needed: ☐ Y ☐ N

ASTHMA ☐ Y ☐ N Recommendations: ______

Inhaler needed: ☐ Y ☐ N Referrals: ______

PHYSICIAN'S NAME/STAMP: ____________

PHYSICIAN'S SIGNATURE: ____________ **PHONE:** ______ **DATE:** ______

SG:sh 2/10/09