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
**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:** ___________

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**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 ☐

**TB Risk Assessment Given by Provider:** Yes ☐ No ☐  
Child has TB Risk? Yes ☐ No ☐

**If Yes, PPD Date Given:**  
**Date Read:**  
**Results:**

**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:**

<table>
<thead>
<tr>
<th>Examination Results</th>
<th>Normal</th>
<th>Abnormal</th>
<th>Describe Findings / Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Appearance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Head, Ears, Eyes, Nose &amp; Throat</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teeth / Gums</td>
<td></td>
<td></td>
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<tr>
<td>Heart / Lung</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abdomen / Genitourinary</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Extremities / Skeletal</td>
<td></td>
<td></td>
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<tr>
<td>Posture and Gait</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neurological (Fine, Gross Motor)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Speech</td>
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<tr>
<td>Skin</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Developmental Status</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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  
**NaF Given:** ☐ No ☐ Yes

**Nutrition Counseling Given:** ☐ No ☐ Yes  
**Nutrition Counseling Referral:** ☐ No ☐ Yes

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**Physician’s Name:** ___________________________  
**Signature:** ___________________________  
**Date:** ___________

**Address:** ___________________________  
**Phone:** ___________________________  
**Fax:** ___________________________

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

<table>
<thead>
<tr>
<th>Date of Service</th>
<th>Tooth # or Letter</th>
<th>Description of Services Provided</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

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

CHILD ORAL HEALTH SUMMARY (check one or more)

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

☐ Needs Treatment:
  ☐ Specialist Referral given: ___________________________ Next Appointment Date: ______________
  ☐ Approx. # of visits needed: ___________________________

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