

Kentucky Eye Examination Form for School Entry

KRS 156.160.8 (g) requires proof of a vision examination by an optometrist or ophthalmologist. This evidence shall be submitted to the school no later than January 1 of the first year that a child is enrolled in public school, public preschool, or Head Start program.

PLEASE COMPLETE THE IDENTIFYING INFORMATION AND RECORDS

IDENTIFYING INFORMATION

Student Name: _____
Date of Birth: _____
Parent or Guardian Name: _____

RECORD OF IMMUNIZATION TO BE REPORTED ON IMMUNIZATION CERTIFICATE FORM, EPID 230

CASE HISTORY

Date of Exam: _____
Ocular History: Normal or Positive for: _____
Medical History: Normal or Positive for: _____
Drug Allergies: Normal or Positive for: _____

Family Ocular and Medical History: Amblyopia Strabismus Glaucoma Diabetes
Other: _____

Other Pertinent Information: _____

Refraction with cycloplegic? (Please indicate one) Yes No

| | OD | OS |
|-----------------------|------------|------------|
| Unaided Acuity | 20 / _____ | 20 / _____ |
| Best Corrected Acuity | 20 / _____ | 20 / _____ |

| | Normal | Abnormal | Not able to Assess |
|---|--------------------------|--------------------------|--------------------------|
| External Exam (eye and adnexa) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Internal Exam (media, lens, fundus, etc.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Neurological Integrity (pupils) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Binocular Function (stereopsis) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Accommodation and convergence | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Color Vision | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Diagnosis: Normal Myopia Hyperopia Astigmatism Strabismus Amblyopia
Other: _____

Recommendations:

- Glasses prescribed: Yes No
- _____
- _____

Age Appropriate and suggested anticipatory guidance (health assessments):

- Educate (parents/patients) about eye/vision disorders and needed vision care
- Counsel (parents/patients) regarding eye safety
- Stress importance of early, preventative eye care
- Recommend re-examination, as appropriate

Signed: _____ Date: _____
Optometrist/Ophthalmologist

Address: _____ Telephone: () _____

Preventative Health Care Examination Form - Initial Entry [Headstart-4th (fourth) grade]

All local boards of education shall require a preventative health care examination of each child entering a Kentucky public school within a period of twelve (12) months prior to initial admission to school. Local school boards may extend this time not to exceed two (2) months. The administration shall have an approved program of continuous health supervision which shall include evidence of having been screened for vision and hearing.

PLEASE COMPLETE THE IDENTIFYING INFORMATION AND RECORDS

IDENTIFYING INFORMATION

Student Name: _____

Social Security Number: _____ Date of Birth: _____

Parent or Guardian Name: _____

RECORD OF IMMUNIZATIONS TO BE REPORTED ON IMMUNIZATION CERTIFICATE FORM, EPID 230

MEDICAL HISTORY

Seizures: _____

Chronic Illness: _____

Allergies: _____

Medications: _____

Significant Historical Information: _____

Physical Exam:

| N. | Abn. | | Hgt: | Wgt: | BP: |
|-------|-------|--------------------|---|-------|----------|
| _____ | _____ | General Appearance | _____ | _____ | _____ |
| _____ | _____ | HEENT | Hearing: R: _____ | | L: _____ |
| _____ | _____ | Skin | Vision: R: _____ | | L: _____ |
| _____ | _____ | Neck | STRABISMUS/AMBLYOPIA SCREEN <input type="checkbox"/> ABNORMAL | | |
| _____ | _____ | Chest | Optional-----HCT/HGB: _____ (required for Headstart) | | |
| _____ | _____ | Heart | Optional-----UA: _____ | | |
| _____ | _____ | Abd-Genitalia | | | |
| _____ | _____ | Extremities-back | | | |
| _____ | _____ | Neuro | | | |

Explain Abnormal Exam: _____

Recommendations:

_____ No Restrictions: Normal Exam
 _____ RESTRICTIONS AND SUGGESTIONS TO SCHOOL: _____

Age Appropriate and Suggested Anticipatory Guidance (health assessment)

- Discuss injury prevention with parents
 - Bicycle Safety
 - Car Seat Belts
 - Memorization of Name, Address and Phone Number
- Advise the child not to go with or accept anything from strangers and feel free to say "NO" to strangers.
- Emphasize the importance of dental care.
- Discuss mental health issues.

Signed: _____ Date: _____
Physician/ARNP/EPSTD Provider

Address: _____ Telephone _____

Preventative Health Care Examination Form - Sixth (6th) Grade Form (for grades 5-12)

All local boards of education shall require a second and third preventative health care examination of each child within one (1) year prior to entry into the sixth (6th) grade or subsequent grades. Each board shall have an approved program of continuous health supervision in accordance with current statutes and regulations, vision, hearing and scoliosis scheduled screening tests. Local school districts shall establish a plan for implementation and compliance with the sixth (6th) grade examination.

PLEASE COMPLETE THE IDENTIFYING INFORMATION AND RECORDS

IDENTIFYING INFORMATION

Grade: 5th 6th 7th 8th 9th 10th 11th 12th *(circle appropriate grade)*

Student Name: _____

Social Security Number: _____ Date of Birth: _____

Parent or Guardian Name: _____

RECORD OF IMMUNIZATIONS TO BE REPORTED ON IMMUNIZATION CERTIFICATE FORM, EPID 230

MEDICAL HISTORY

Seizures: _____

Chronic Illness: _____

Allergies: _____

Medications: _____

Significant Historical Information: _____

Physical Exam:

| N. | Abn. | | | | |
|-------|-------|---|-----------------------------|------------|-----------|
| _____ | _____ | General Appearance | Hgt: _____ | Wgt: _____ | BP: _____ |
| _____ | _____ | HEENT | Hearing: R: _____ | | L: _____ |
| _____ | _____ | Skin | Vision: R: _____ | | L: _____ |
| _____ | _____ | Neck | Optional-----HCT/HGB: _____ | | |
| _____ | _____ | Chest | Optional-----UA: _____ | | |
| _____ | _____ | Heart | | | |
| _____ | _____ | Abd-Genitalia | | | |
| _____ | _____ | Extremities-back (including scoliosis screen for 6th grade) | | | |
| _____ | _____ | Neuro | | | |

Explain Abnormal Exam: _____

Recommendations:

_____ No Restrictions: Normal Exam
 _____ RESTRICTIONS AND SUGGESTIONS TO SCHOOL: _____

Age Appropriate and Suggested Anticipatory Guidance (Health Assessment)

1. How have things been going for you at school? With your peers?
2. How do you rate your own health?
3. What concerns do you have about your own development?

Advise adolescents about the following good health habits and self-care. -See sample reference on back of form.

- Risk Behaviors were discussed and addressed
 Risk Behaviors were not addressed today

Signed: _____ Date: _____
Physician/ARNP/EPSTD Provider

Address: _____ Telephone: _____

Guidelines Only - Please do not mark risk factors on this form.

| | Low Risk | Moderate Risk | High Risk |
|---|--|--|--|
| Body Mass Index | Between 15-85% Normal weight/height per the growth chart | Between 5-15%/85-95% (Just over or just under the normal range) | <5%/>95% (Much over or much under normal weight) |
| Weight perception | Feels good about weight | Feels “fat” even though weight is normal on the chart | Skips meals, vomits, takes medicine, or exercises too much to control weight |
| Nutrition | Eats 3 meals/day; and eats fruits, vegetables, and foods with fiber | Eats less than 3 meals/day; or vegetarian without milk or eggs | Eats a lot of snacks with fat and sugar, eats few regular meals |
| Exercise | 5 times/week for at least 20 min. each, with increased heart rate and sweating | Exercises less than 5 times/week, not strenuously | No regular exercise to increase heart rate |
| Tobacco use | No smoke or chew | Smoke or chew less than daily; or stopped less than 6 weeks ago | Smoke or chew regularly |
| Drug use | Never used | Previously used; not in the past 3 months | Recently used or currently uses marijuana, huffing, LSD, cocaine, heroin, etc. |
| Alcohol use | Has only tasted it, or used for religious purpose | Social only, not more than once/week; less than 3 beers or 2 liquor drinks at a time | Drunkness, blackouts; drinking interferes w/school, family, etc.; 4 or more drinks at a time |
| Sexual activity | Never, or is married and faithful | Not in last 6 months; safe sex with condoms | Sex <u>without</u> regular use of condoms; first intercourse before age 16 |
| School | B/C average or better, steady improvement in grades | Grades slipping; detention problem | Failing grades; suspension; often skips school |
| Depression | Usually happy | Often feels discouraged or down; cries a lot | Unhappy <u>most</u> of the time: feels hopeless, thought of suicide |
| Abuse | No physical or sexual abuse | Abuse reported and counseling received | Abuse still occurring or not treated with counseling |
| Safety | Uses seat belt/helmet, never rides with drunk driver | Usually uses seat belt/helmet; rarely rides with drunk driver | Does not use seat belt/helmet; has driven drunk; sometimes rides with drunk driver |
| Violence | No fights, no threats, does not carry a knife, gun, or rifle, no legal troubles | Threatens others; previous illegal acts (stealing, etc.) but not in past 3 months | Damages own or others’ property; carries a gun, knife, or rifle; physical fights with peers; has had contact with police |
| Family relationships and responsibility | Gets along with family, completes chores or work duties | Often argues with family; does not complete chores or work duties | Physical and/or intense verbal fights with family |
| Friends and recreation | Has male and female friends; involved in clubs, activities or hobbies | Has few friends; does things alone; has friends who often get into trouble | Has no friends; or belongs to gang or cult |
| Good qualities and future plans | Can name 3 good qualities about self; has plans for the future | Hard to think of good qualities about self; has few interests; does not have future | No good qualities about self; no interests or activities |
| Immunizations | Second MMR; tetanus within ten years; hepatitis series; had varicella or been vaccinated | Lacks any one item | Lacks two or more items |

Jefferson County Public Schools
Pupil Personnel, Health Services

Vision Service Plan—Sight for Students Application for Free Eye Examination and Glasses

Name of Student: _____ Date of Birth: _____

School: _____ Grade: _____

Address: _____ Soc. Sec. No.: _____

City: _____ State: _____ Zip Code: _____ Home Telephone: _____

Parent/Guardian Name: _____

Relationship to Student: _____

Daytime Telephone: _____ Evening Telephone: _____ Emergency No.: _____

Reason for Request (no vision insurance, not eligible for medical assistance, financial reasons, etc.):

Proof of Income: Please attach copies of a payroll stub or income tax return to verify annual income.

Annual income: \$ _____ Number of persons depending on this income: _____

Parent/Guardian: This is to certify that the above information is correct to the best of my knowledge.

Signature: _____ Date: _____

Person responsible for assisting with this application: (school staff, FRYSC coordinator, Neighborhood Place, etc.)

Name: _____ Title: _____

Location: _____ Telephone: _____

Return Application and Proof of Income to: Jefferson County Public Schools, Office of Health Services, Room 201, Lam Bldg.
P. O. Box 34020-4020, Louisville, KY 40232-4020 **or** Fax to: 485-3670

Questions: 485-3387

HS (GB EXAM FORMS) 6-28-01

KENTUCKY DEPARTMENT OF EDUCATION
MEDICAL EXAMINATION OF SCHOOL EMPLOYEES*

Name: _____ Date of Birth: _____ Sex: M _____ F _____

Address: _____ Telephone: _____

Applicant with or Employed by: _____ Board of Education

HISTORY

Medical (All serious medical and psychiatric diseases: Diabetes, Epilepsy, Heart Condition, etc.):

Surgical (All major operations.): _____

Family History (T.B., Epilepsy, Diabetes, etc.): _____

PHYSICAL

- | | |
|----------------------------------|---------------------------------------|
| 1. General Appearance: _____ | 7. Blood Pressure: _____ Pulse: _____ |
| 2. Eyes: _____ | 8. Lungs: _____ |
| 3. Ears, Nose, and Throat: _____ | 9. Abdomen: _____ |
| 4. Teeth and Gums: _____ | 10. Nervous System: _____ |
| 5. Thyroid: _____ | 11. Extremities: _____ |
| 6. Heart: _____ | 12. Other: _____ |

| | | |
|----------------------------------|------------------|---|
| T.B. Skin Test | | Date X-ray Taken: _____ |
| Date Given: _____ | Date Read: _____ | OR |
| Type of Test: _____ | By Whom: _____ | <input type="checkbox"/> No further follow-up necessary unless signs/symptoms of tuberculosis develop |
| Millimeters of Induration: _____ | | |

TEAR OFF THIS PORTION AND RETURN IT TO THE SCHOOL SUPERINTENDENT'S OFFICE

CERTIFICATION OF MEDICAL EXAMINATION

This is to certify that I have examined _____ and find him/her free of communicable disease and any physical or mental disabilities that might interfere with performing his/her duties, except as follows: _____

Date of Examination

Signature (Physician/PA/ARNP)

*A separate form is provided for bus drivers.