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Section V - CHDPP

CHILD HEALTH AND DISABILITY PREVENTION (CHDP) PROGRAM INFORMATION

1. School District Responsibility

CHDP - the Child Health and Disability Prevention Program is a preventive health program serving California's children and youth. It is administered and financed by the State Department of Health Services. The Program is designed for early identification and remediation of health problems. This will assist children in reaching their academic potential and personal well being.

Since 1975, Pasadena Unified School District has implemented procedures that conform with California law which requires all children entering first grade to have received a health screening examination within the preceding 18 months or within 90 days after entry into first grade (H & SC 321.2). School districts are required to inform the parent/guardian of entering kindergarten students regarding CHDP program provisions (H & S.C. 324.2).

In accordance with H & S.C. 323.5, C.A.C. Title 17, 6802 (a)(3), the school district informs the parent/guardian of all registered first grade students without certificates that within 90 days of school entry, a certificate documenting that the pupil has had the required health screening within the prior 18 months must be presented to the school or a waiver may be signed.

Parents may meet this requirement by taking the child to: 1) their Health Care Provider, 2) a prepaid health plan (Kaiser Permanente or others), 3) The Health Dept., or 4) PUSD Health Clinics.

The school setting continues to be an ideal location for a cost-effective CHDP program:

- A professional team exists in the school to help resolve student problems: school nurse, teacher, speech specialist and psychologist.

- Other children in the family may also qualify for an examination.

- Schools have an established framework for confidential record keeping and transference.

- Health-related problems which affect achievement and attendance are identified and resolved earlier, some prior to school entry.

- Follow-up is an integral part of health services since the child's health is seen as related to success.

As a CHDP provider, the Pasadena Unified School District Health Services Clinic is able to administer the required physical examinations for first grade as well as Head Start and State Preschool students. Services to students K-12 are also provided to low-income children whose families meet federal guidelines. Health conditions which may have significant implications for learning can be detected through screening examinations and referred for medical and/or educational intervention.

The CHDP screening examination includes:

a. a health and developmental history
b. an assessment of physical growth
c. ear, nose, mouth and throat inspection, including inspection of teeth and gums
d. screening tests for vision, hearing, anemia, tuberculosis, diabetes and urinary tract conditions
e. an unclothed examination for obvious physical defect
f. examination and referral for sexually transmitted diseases (age appropriate)
g. an assessment of nutritional status
h. an assessment of immunization status and provision of needed immunizations
i. referral for lead poisoning and other tests which may be necessary to identify children with potential disabilities requiring diagnosis and possible treatment (H. & S.C. 321.2)
j. anticipatory guidance and health education appropriate to age and health status including the harmful effects of the use of tobacco products and exposure to secondary smoke

Written documentation signed by the screening provider or a waiver certificate signed by the parent must be included in the pupil record (C.A.C., Title 17, 6845 and 6802). The Pasadena Unified School District makes every possible effort to encourage families to obtain an examination rather than sign a waiver.

The Superintendent of Public Instruction may withhold state average daily attendance funds from any school district for any child for whom certification of physical exam or parental waiver is not obtained (H. & S.C. 324.2).

It is the responsibility of the school health office staff (nurses and health assistants) to schedule students for appointments at the School Health Clinic. Clinic personnel may be asked to assist with scheduling when necessary.

2. PROCEDURE FOR HEALTH SERVICES CLINIC PHYSICAL EXAMINATIONS

Information needed for Physical Exam

A. Eligibility

1. The family must meet the state financial eligibility schedule (refer to Eligibility Determination Table) and be from birth to age 18.

or

2. **The child must be certified Medi-Cal eligible by the County Welfare Department, (Medi-Cal), be between birth and 20, and be eligible for CHDP service according to their age, sex, and health history if they are not enrolled in a Prepaid Health Plan (PHP), or Health Maintenance Organization HMO**

or

3. Children attending Head Start and State Pre-School program must have a physical examination within 90 days after registering in the program.

   - A report of the examination will be enclosed in their Health Records
     An effort should be made to obtain this record when the child enters kindergarten.
   - If the examination was completed prior to March 1 of the year the child enrolled in preschool, the examination does not meet the first grade requirement. The child will need another examination.

or

4. Parent may choose to pay $50.00 when child does not qualify under 1, 2, or 3 above.

B. Forms needed:

1. Physical Examination Letter

2. Information sheet for CHDP Physical Exam

3. Consent Form

4. Health History

C. Schedule an Appointment

1. Send home a Physical Exam letter to determine eligibility.

2. Children who are eligible and have checked number 1, 2 or 3 on the Physical Exam Letter, send home Health History, Consent and School Nurse Practitioner Examination half sheet (see samples). Note date on worksheet.

3. If number 4, 5, 6 is checked on the Physical Exam Letter, call the parent and ask if appointment has been made for a physical exam. (Note on your worksheet the date you contacted the parent).
   (If they have a physician appointment, send the Report of Health Care Provider for School Use form home. Make a note on your worksheet).

4. When parent returns Health History and Consent, pull record of child.

   a. Complete Information Sheet (see sample) **If height, weight, vision and hearing have been done, record results on Information Sheet.**

   b. Attach the following forms:

      1. Information sheet for CHDP exam
      2. Consent Form
      3. Health History
      4. Physical Examination Letter

5. Call district clinic at Ed. Center for available appointment times at (626) 396-3600 –Ext. 88180

6. Call parent with available appointment times. Then contact clinic with date and time chosen by parent.

7. Mail completed forms to district clinic as soon as appointment is made.

8. Instructions to parents regarding appointments.

   a. Payment:

      1. If student has Medi-Cal insurance, remind parent to bring Medi-Cal card.

      2. If family is to pay cash, they must bring cash- <u>NO CHECKS ARE ACCEPTED</u>.

   b. Emphasize to Parent:

      1. Location of clinic - room #130

      2. <u>Be on time</u>

      3. Remind parents to bring in all original immunization records

      4. Please call to cancel or to reschedule if unable to make appointment
         (626) 396-3600 – Ext. 88180.

      5. Parent or caregiver **<u>must be present</u>** to provide needed information and receive advice about well child care. Referral for treatment will be made as necessary.

9. After appointments are made:

   a. One or two days before the appointment is scheduled, send home the map with the time and date of the appointment. Call parent as a reminder.

10. After receiving a copy of the CHDP Exam, record the date on the front of the health record. If the child has received immunizations during the exam, place this on front of health record and on blue CSIR Card in health record.

11. Leave health record out for the School Nurse to check and record on the inside of the record.

D. Points to Remember

- Please use CHDP periodicity schedule when scheduling Medi-Cal or income eligible students.
- Encourage periodic exams for ALL children. Ask about siblings.
- Students may be examined more often than the periodicity table allows under the following circumstances:
    - Child is in foster care - may have an exam every year.
    - A child needing an examination to meet first grade requirements whose examination was done at least one year before.
    - Sports/camp examinations may be given yearly.
    - A child not showing appropriate growth and development for their age.
    - A child with some indication or suspicion of abuse, neglect or failure to thrive.
    - Immature or inexperienced young mothers with their child or signs of a poor mother - child relationship.
    - Children with a significantly handicapping condition may have one CHDP examination every year after age 2.

3. FIRST GRADE MANDATE REPORT:

A. In the fall, review first grade records to determine if child has had a physical examination.

B. Initiate worksheet to determine who does not have an examination on file.

C. If child has not had an examination, put their name on the worksheet.

D. If they have a medical appointment, send the private physician's form home, make a note on worksheet.

E. After receiving CHDP Physical Examination or PMD form, mark "completed" on the worksheet with the date. (Refer to sample)

NOTE: All first grade students must have either a physical examination form or a waiver on file by early December or they **WILL BE EXCLUDED** as per the Hughes Children Health Enforcement Act (AB52)

THE STATE MANDATED CHDP REPORT NEEDS TO BE COMPLETED AND SUBMITTED TO HEALTH PROGRAMS BY MID-DECEMBER.

PASADENA UNIFIED SCHOOL DISTRICT
HEALTH PROGRAMS

CHDP WORK SHEET

From__________to____________ School______________________Grade________ (Please keep this work sheet and the report in the file in front of the Kindergarten records)

Name/Phone # of student without exam or waiver	Name Medical Provider or Clinic	SNP to do	Appt. date	Date of contact with parent (Direct contact only)					Comments

INDIVIDUAL SCHOOL DATA REPORT
CHILD HEALTH AND DISABILITY PREVENTION PROGRAM

SCHOOL _____ DATE _____

PERSON PREPARING REPORT _____

PHONE NUMBER _____

Total Number of Children Enrolled in First Grade at Time Report Prepared Columns 2,3,4,5&6) (1)	Number of Children With Report of Health Examination for School Entry (PM171 A) On File (2)	NUMBER OF CHILDREN WITH WAIVER BECAUSE:			Number of Children with Neither Documentation Nor Waiver of Examination On File (6)
		Parent Does Not Want the Examination (3)	Parent Unable to Obtain the Examination (4)	Reason Not Specified (5)	

PASADENA UNIFIED SCHOOL DISTRICT
HEALTH PROGRAMS

1st GRADE/KINDERGARTEN PHYSICAL EXAMINATION ELIGIBILITY LETTER

Dear Parent/Guardian:

The state of California requires that each child enrolling in the first grade must have a physical examination. Please check below how you plan to meet this state requirement for your child.

CHECK ONE

1. _____School Nurse Practitioner (Paid by state - See School Nurse).
3. _____School Nurse Practitioner (Paid by family - $50.00 cash only).
4. _____Pasadena Department of Human Services - Health Division.
5. _____Prepaid Health Plan (i.e. Kaiser or other).
6. _____Personal Provider (Forms are available at school office).
7. _____Physical examinations are against my belief. **(Waiver MUST be signed)**

****

INCOME ELIGIBILITY

1. Number of persons in family? _____
2. Is the patient:
   a. On Medi-Cal now? ☐ Yes ☐ No
   b. On a Prepaid Health Plan (Kaiser or other)? ☐ Yes ☐ No
   c. Does your child receive free/reduced lunch? ☐ Yes ☐ No

****

_____ _____
(School) (Child's Name)

_____ _____
(Parent's Work Phone #) (Birthdate)

_____ _____
(Parent's Home Phone #) (Signature of Parent/Guardian)

_____
(Date)

DISTRITO ESCOLAR UNIFICADO DE PASADENA
PROGRAMAS DE SALUD

CARTA DE ELIGIBILIDAD PARA EXAMEN FISICO
DE PRIMER GRADO/KINDERGARTEN

Estimado Padre/Tutor:

El estado de California requiere que cada niño matriculado en el primer grado debe tener un examen físico. Por favor marque abajo como planea cumplir con este requerimiento del estado para su hijo/a.

MARQUE UNO ( )

1. ____Enfermera Profesional Escolar (Pagada por el Estado - Vea la Enfermera de la Escuela).
3. ____Enfermera Profesional Escolar (Pagada por la familia - $50.00 al contado únicamente).
4. ____Departamento de Servicios Humanos de Pasadena - División de Salud.
5. ____Plan de salud pre-pagado (ej. Kaiser u otro).
6. ____Proveedor Personal (las formas se pueden obtener en la oficina de la Escuela).
7. ____Los examenes físicos son en contra de mis creencias. **(Se debe firmar una Renuncia)**

****

INGRESOS DE ELEGIBILIDAD

1. ¿Número de personas en la familia? _____
2. Está el paciente:
   a. ¿En Medi-Cal ahora? ☐ Sí ☐ No
   b. ¿En un Plan de Salud Prepagado (Kaiser u otro)? ☐ Sí ☐ No
   c. ¿Recibe su niño/a almuerzo gratis o de costo reducido? ☐ Sí ☐ No

****

_____ _____
(Escuela) (Nombre del/a Niño/a)

_____ _____
(No. de Tel. del Trabajo del Padre) (Fecha de Nacimiento)

_____ _____
(No. de Tel. del Hogar del Padre) (Firma del Padre/Tutor)

_____
(Fecha)

PASADENA UNIFIED SCHOOL DISTRICT
HEALTH PROGRAMS

SCHOOL NURSE PRACTITIONER EXAMINATION
(COVER LETTER)

Date _____

Name_____ School_____

Dear Parent/Guardian:

When you registered your child in school, you indicated your wish to have the School Nurse Practitioner give the required physical examination to your child.

Enclosed you will find a Health and Development History form and a Consent for Physical Examination form that must be filled out and returned to the School Health Office immediately. After receiving these forms, we will contact you to set up an appointment for a physical examination for your child.

A parent/guardian must accompany the child for the physical examination held at the Board of Education at 351 S. Hudson Avenue, in the Clinic - Room 130.

Sincerely,

_____
Nurse or Health Clerk

PASADENA UNIFIED SCHOOL DISTRICT
HEALTH PROGRAMS

SCHOOL NURSE PRACTITIONER EXAMINATION
(COVER LETTER)

Date _____

Name_____ School_____

Dear Parent/Guardian:

When you registered your child in school, you indicated your wish to have the School Nurse Practitioner give the required physical examination to your child.

Enclosed you will find a Health and Development History form and a Consent for Physical Examination form that must be filled out and returned to the School Health Office immediately. After receiving these forms, we will contact you to set up an appointment for a physical examination for your child.

A parent/guardian must accompany the child for the physical examination held at the Board of Education at 351 S. Hudson Avenue, in the Clinic - Room 130.

Sincerely,

_____
Nurse or Health Clerk

DISTRITO ESCOLAR UNIFICADO DE PASADENA
PROGRAMAS DE SALUD

EXAMEN FISICO POR LA ENFERMERA PROFESIONAL DE LA ESCUELA

Fecha_____

Nombre_____ Escuela_____

Estimado Padre/Tutor:

Cuando matriculó a su niño/a en la escuela, Ud. indicó el deseo de que la Enfermera Profesional Escolar le diera a su niño/a el examen físico requerido.

Adjunto encontrará un formulario de Historia de Salud y Desarrollo y un formulario de Consentimiento para el Examen Físico, el cual debe llenarse y regresarse inmediatamente a la Oficina de Salud de la Escuela. Después de recibir estos formularios, nos comunicaremos con Ud. para hacer una cita para el examen físico de su niño/a.

El padre/tutor debe de acompañar al niño/a para el examen físico. Los examenes se hacen en la Clínica, Sala #130 del Centro de Educación, en el 351 South Hudson Ave., Pasadena.

Cordialmente,

_____
Enfermera o Ayudante

DISTRITO ESCOLAR UNIFICADO DE PASADENA
PROGRAMAS DE SALUD

EXAMEN FISICO POR LA ENFERMERA PROFESIONAL DE LA ESCUELA

Fecha_____

Nombre_____ Escuela_____

Estimado Padre/Tutor:

Cuando matriculó a su niño/a en la escuela, Ud. indicó el deseo de que la Enfermera Profesional Escolar le diera a su niño/a el examen físico requerido.

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El padre/tutor debe de acompañar al niño/a para el examen físico. Los examenes se hacen en la Clínica, Sala #130 del Centro de Educación, en el 351 South Hudson Ave., Pasadena.

Cordialmente,

Enfermera o Ayudante

PASADENA UNIFIED SCHOOL
DISTRICT HEALTH PROGRAMS

CONSENT FORM FOR PHYSICAL EXAMINATION

I hereby give consent for_____, my son/daughter to receive a complete physical examination by the nurse practitioner.

This may include: a head to toe unclothed assessment, hemoglobin, urinalysis, tuberculosis skin test, vision, hearing and any recommended immunizations.

I also authorize release of information concerning the results of these screening tests to my health care provider.

_____ _____

Date Parent/Guardian Signature

PASADENA UNIFIED SCHOOL
DISTRICT HEALTH PROGRAMS

CONSENT FORM FOR PHYSICAL EXAMINATION

I hereby give consent for_____, my son/daughter to receive a complete physical examination by the nurse practitioner.

This may include: a head to toe unclothed assessment, hemoglobin, urinalysis, tuberculosis skin test, vision, hearing and any recommended immunizations.

I also authorize release of information concerning the results of these screening tests to my health care provider.

_____ _____

Date Parent/Guardian Signature

DISTRITO ESCOLAR UNIFICADO DE PASADENA
PROGRAMAS DE SALUD

FORMA DE CONSENTIMIENTO PARA EXAMEN FISICO

Por medio de la presente doy mi consentimiento para que mi hijo/a, _____ _____, reciba un examen físico completo dado por la enfermera profesional.

Este examen incluirá: una evaluación de pies a cabeza desnudo, un análisis de hemoglobina (sangre), orina, vacuna para la tuberculosis, examen de la vista y del oído y las inmunizaciones necesarias.

También doy mi autorización para que den información acerca de los resultados de estas pruebas a mi médico privado.

_____ _____
Fecha Firma del padre/tutor

DISTRITO ESCOLAR UNIFICADO DE PASADENA
PROGRAMAS DE SALUD

FORMA DE CONSENTIMIENTO PARA EXAMEN FISICO

Por medio de la presente doy mi consentimiento para que mi hijo/a, _____ _____, reciba un examen físico completo dado por la enfermera profesional.

Este examen incluirá: una evaluación de pies a cabeza desnudo, un análisis de hemoglobina (sangre), orina, vacuna para la tuberculosis, examen de la vista y del oído y las inmunizaciones necesarias.

También doy mi autorización para que den información acerca de los resultados de estas pruebas a mi médico privado.

_____ _____
Fecha Firma del padre/tutor

SCHOOL BASED HEALTH CENTER

ELEMENTARY SCHOOLS
HEALTH HISTORY FORM (to be filled out by parent)

Child's Name _____ Grade _____
Last *First* *Middle*
Birthdate _____ Sex: ___Male ___Female School _____

Child's Birth Order (1,2,3 etc.) Phone _____ Medi-Cal No. _____

Parent's Name _____ Address _____
Street *City* *Zip*

---

1. MATERNAL & INFANT HISTORY

a. MATERNAL HISTORY

Complications of Pregnancy: No____Yes___
Specify _____
_____
Duration : Pregnancy_____months
Labor_____hours
Delivery Method _____
Medication/Drugs taken during pregnancy? No Yes ___

b. INFANT HISTORY

Condition of Newborn _____
Birth Weight:_____lbs._____ozs.
1st month complications: No_____Yes ___
Specify _____
_____
_____
_____

---

2. PAST MEDICAL HISTORY AND ILLNESSES (Mark with X)

	Yes		Yes		Yes
Allergies	___	Red Measles (10 Day)	___	Heart Disease	___
Anemia	___	Chicken Pox	___	Kidney Disease	___
Asthma	___	Mumps	___	Meningitis	___
Diabetes	___	Rubella (3 day)	___	Sickle Cell	___
Drug Allergy	___	Scarlet Fever	___	Convulsions	___
Epilepsy	___	Whooping Cough	___	Rheumatic Fever	___
Ear Infections	___	Tuberculosis	___	Meningitis	___
Frequent Colds	___	Polio	___	Alcoholism	___
Sore Throats	___	Diphtheria	___	Smoking	___
Wheezing	___	Pneumonia	___	Substance Abuse	___
High Blood Pressure	___	Hospitalizations	___	Surgeries	___

Other _____

---

3. FAMILY HISTORY (Mark with X the conditions any family members have had)

	Yes		Yes		Yes
Rheumatic Fever	___	Syphilis	___	Mental Retardation	___
Tuberculosis	___	Bleeding Disorder	___	Mental Disease	___
Diabetes	___	Jaundice	___	Obesity	___
Epilepsy	___	Kidney Disease	___	Birth Defects	___
Cancer	___	Asthma	___	Alcoholism	___
Hypertension	___	Anemia	___	Smoking	___
Heart Disease	___	Allergies	___	Substance Abuse	___

If "Yes", specify family member and condition _____

---

4. GENERAL HEALTH, FAMILY (Mark with X)

	Good	Fair	Poor	(Briefly explain)
Mother	___	___	___	_____
Father	___	___	___	_____
Siblings	___	___	___	_____

Date _____ Signed _____
Parent or Guardian

CENTRO DE SALUD ESCOLAR

ESCUELA PRIMARIA
FORMA DE HISTORIA DE SALUD (para que la completen los padres)

Nombre del Niño _____ Grado _____
Apellido *Nombre* *Inicial*

Fecha de Nacimiento _____ Sexo: Masculino Femenino Escuela _____

Orden de Nacimiento del Niño (1,2,3, etc.) Teléfono _____ Medi-Cal No. _____

Nombre del Padre _____ Domicilio _____

1. HISTORIA MATERNA Y DEL INFANTE

a. HISTORIA MATERNA

Complicaciones del Embarazo: No____ Sí____
Especifique _____

Duración: Embarazo _____ meses
Parto _____ horas
Forma de Parto _____

b. HISTORIA DEL INFANTE

Condición del Recién Nacido _____
Peso al Nacer: _____ lbs. ____ ozs.
Complicaciones el 1er, mes: No____ Sí ____
Especifique _____

2. HISTORIA MEDICA Y DE ENFERMEDADES (Marque con X)

	Sí		Sí		Sí
Alergias	___	Sarampión (10 días)	_____	Enfermedad del Corazón	____
Anemia	___	Varicella	_____	Enfermedad de los	
Asma	___	Paperas	_____	Riñones	___
Diabetes	___	Rubela (3 días)	_____	Meningitis	___
Alergia a Medicinas	____	Fiebre Escarlatina	_____	Célula Falsiforme	____
Epilepsia	___	Tos Ferina	_____	Convulsiones	____
Infección de Oídos	____	Tuberculosis	_____	Fiebre Reumática	____
Resfríos Frecuentes	____	Polio	_____	Meningitis	___
Dolor de Garganta	____	Difteria	_____	Alcoholismo	___
Resuello Dificultoso	____	Pulmonía	_____	Fuma	___
Alta Presión Arterial	____	Hospitalizaciones	_____	Abuso de Sustancias	
		Operaciones	_____	Restringidas	___

Otras Enfermedades _____

3. HISTORIA FAMILIAR (Marque con X las enfermedades que cualquiera de los miembros de la familia hayan tenido)

	Sí		Sí		Sí
Fiebre Reumática	____	Sífilis	___	Retardo Mental	____
Tuberculosis	____	Hemorragias	___	Enfermedad Mental	____
Diabetes	____	Ictericia	___	Obesidad	___
Epilepsia	___	Enfermedad de los Riñones	____	Defectos de Nacimiento	____
Cáncer	____	Asma	___	Alcoholismo	____
Alta Presión	____	Anemia	___	Fuma	___
Enfermedad del Corazón	_____	Alergias	___	Abuso de Sustancias	
Si la respuesta es afirmativa, especifique el miembro de la familia y la condición _____				Restringidas	____

4. SALUD GENERAL DE LA FAMILIA (Marque con X)

	Buena	Regular	Mala	(Explique Brevemente)
Madre	_____	_____	_____	_____
Padre	_____	_____	_____	_____
Hermanos/as	_____	_____	_____	_____

Fecha _____ Firma _____
Padre o Tutor

PASADENA UNIFIED SCHOOL DISTRICT
HEALTH PROGRAMS _____
(Please pencil in date & time of appointment)

INFORMATION SHEET FOR CHDP PHYSICAL EXAM

Funding 1 2 3 (please circle)

NAME_____ SCHOOL_____ TEACHER_____

BIRTHDATE____/_____/_____ SEX_____ ETHNIC ORIGIN_____ GRADE _____

ADDRESS_____ CITY/STATE_____ ZIP _____

PARENT'S NAME_____ HOME PHONE_____ WORK PHONE _____

Height_____ Weight_____ Date / / Vision Rt._____ Lt._____ Cover_____ Date / /

Hearing Rt._____ Lt._____ Date / /

Special Problems/Communicable Diseases _____

_____

Immunization Dates:

DPT 1_____ 2_____ 3_____ 4_____ 5 _____ Tdap _____

Polio 1_____ 2_____ 3_____ 4_____ 5 _____

MMR 1_____ 2_____ Varicella_____

Measles_____ Rubella_____ Mumps_____ PPD_____ Result _____

Hepatitis B 1_____ 2_____ 3_____ HIB 1_____ 2_____ 3 _____

PASADENA UNIFIED SCHOOL DISTRICT
HEALTH PROGRAMS _____
(Please pencil in date & time of appointment)

INFORMATION SHEET FOR CHDP PHYSICAL EXAM

Funding 1 2 3 (please circle)

NAME_____ SCHOOL_____ TEACHER_____

BIRTHDATE____/_____/_____ SEX_____ ETHNIC ORIGIN_____ GRADE _____

_____

ADDRESS_____ CITY/STATE_____ ZIP _____

PARENT'S NAME_____ HOME PHONE_____ WORK PHONE _____

Height_____ Weight_____ Date / / Vision Rt._____ Lt._____ Cover_____ Date / /

Hearing Rt._____ Lt._____ Date / /

Special Problems/Communicable Diseases _____

_____

Immunization Dates:

DPT 1_____ 2_____ 3_____ 4_____ 5 _____ Tdap_____

Polio 1_____ 2_____ 3_____ 4_____ 5 _____

MMR 1_____ 2_____ Varicella _____

Measles_____ Rubella_____ Mumps_____ PPD_____ Result _____

Hepatitis B 1_____ 2_____ 3_____ HIB 1_____ 2_____ 3 _____

PASADENA UNIFIED SCHOOL
DISTRICT HEALTH PROGRAMS CLINIC

APPOINTMENT REMINDER & MAP

Your child_____has an appointment on

_____ _____ _____
Day Date Time

_____ For a physical examination.

_____ Needs to return for follow-up. _____

_____ Please bring all immunization records.

_____ If your child is on Medi-Cal bring his/her current card.

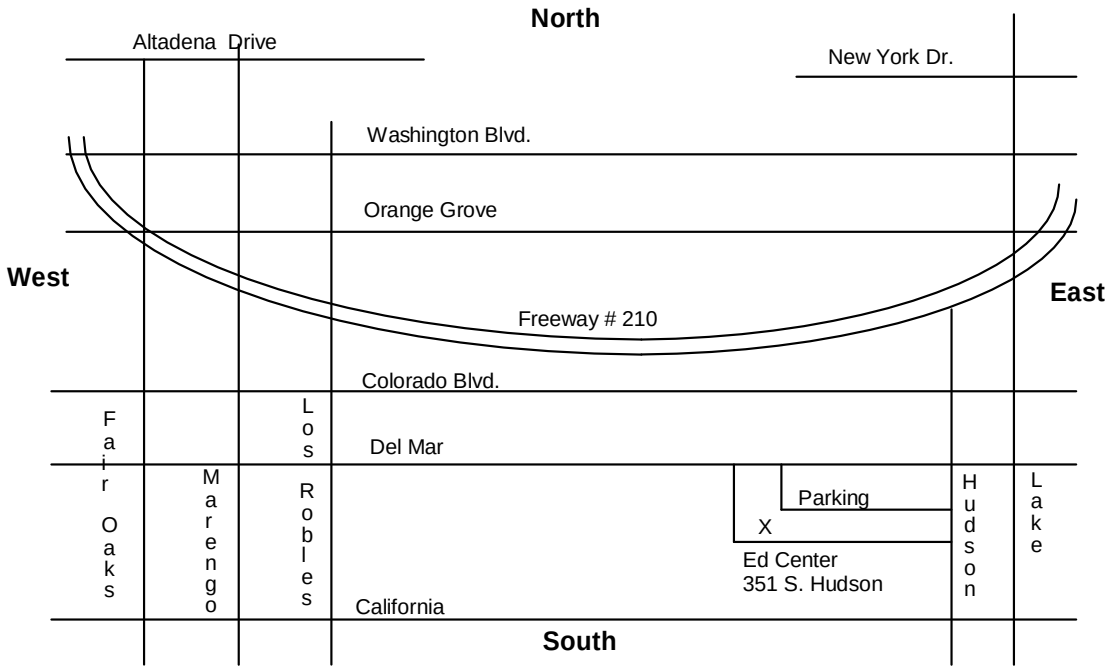
PLACE: PASADENA UNIFIED SCHOOL DISTRICT
HEALTH PROGRAMS CLINIC
351 South Hudson Ave., Room #130
Pasadena, CA 91109

PHONE: (626) 396-3600 Ext. 88180

***** If for any reason you cannot keep this appointment, please notify us as soon as possible at *****
the telephone number listed above.

Thank you,

_____
Nurse or Health Clerk



DISTRITO ESCOLAR UNIFICADO DE PASADENA CLINICA DE PROGRAMAS DE SALUD

RECORDATORIO DE CITA & MAPA

Su hijo/a_____tiene cita para el

_____ _____ _____

DIA FECHA HORA

_____Para examinación física.

_____Necesita regresar. _____

_____Por favor traiga el libro de las vacunas.

_____Si su hijo/a recibe Medi-Cal, traiga su tarjeta.

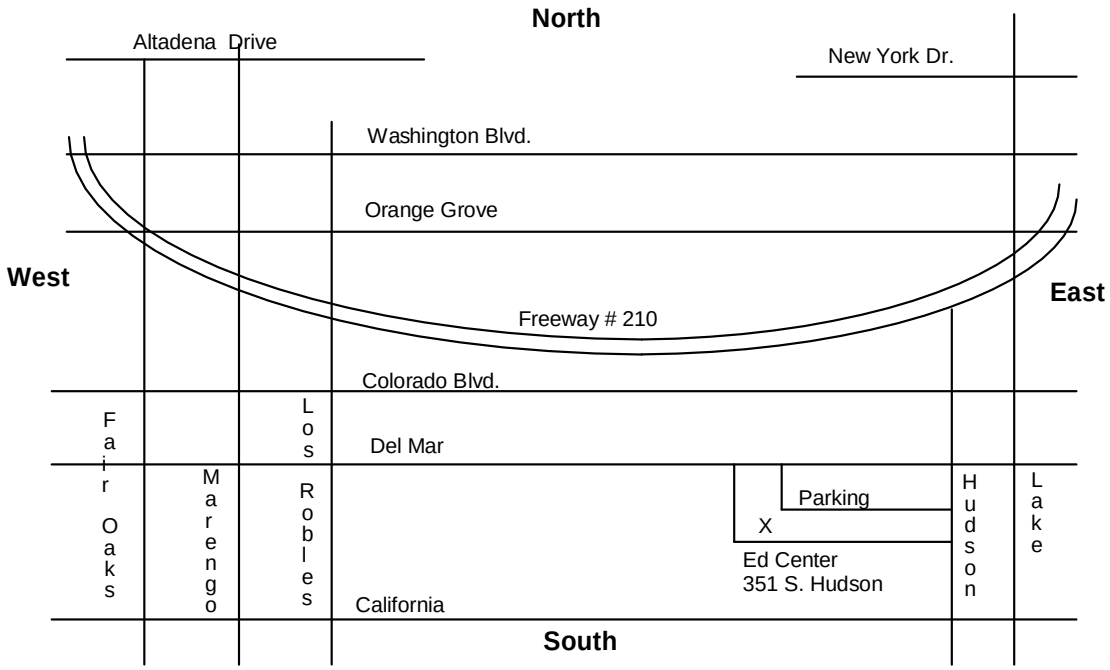
LUGAR: DISTRITO ESCOLAR UNIFICADO DE PASADENA
CLINICA DE PROGRAMAS DE SALUD
351 S. Hudson Ave., Cuarto 130
Pasadena, CA 91109

TELÉFONO: (626) 396-3600 – Ext. 88180

***** Si por cualquier razón used no puede cumplir con esta cita por favor llame al número de *** teléfono apuntado arriba.**

Gracias,

_____
Enfermera o Ayudante



PASADENA UNIFIED SCHOOL DISTRICT
EDUCATION CENTER • HEALTH PROGRAMS

PHYSICAL EXAMINATION FOR FIRST GRADE STUDENTS

Date: _____

To the Parents of,_____

The California Legislature recognizes the importance of health to learning and to a successful academic career. Thus, the "Hughes Children's Health Enforcement Act" (AB52) which became effective January 1[51] 1992 requires school district to ensure that pupils receive a health screening 18 months prior to entering first grade, or within 90 days after first grade begins,

Please provide the school with one of the following:

A. Valid physical examination screening certificate signed by a medical provider. The examination must have been completed WITHIN THE PAST 18 MONTHS,

B. Signed waiver for a health screening, (Health and Safety Code Section 324,3)

To date we do not have either a copy of the physical examination or a waiver on file for your child. This requirement must be met by_____or your child will be excluded from school.

If you have any questions, please call your school nurse or health clerk

Thank you for your cooperation in this matter.

Sincerely,

Ann Rector
Director of Health Programs

APPROVED:

Dr. Shawn Bird
Chief Academic Officer

351 South Hudson Avenue ·Pasadena, CA 91109
(626) 396-3600 Ext. 88240 , Fax (626) 584-1540
www.pusd.us

PASADENA UNIFIED SCHOOL DISTRICT
EDUCATION CENTER . HEALTH PROGRAMS

EXAMEN FISICO PARA LOS ESTUDIANTES DE PRIMER GRADO

Fecha_____

A los Padres de,_____

La Legislatura de California reconoce la importancia de la salud para que los alumnos aprendan y tengan una carrera academica exitosa. Debido a esto, el Acta Obligatoria de la Salud Infantil de Hughes (AB52), efectiva el 1° de enero de 1992 requiere que el distrito escolar se asegure que los alurnnos reciban un examen medico 18 meses antes de comenzar el primero grado, o dentro de 90 dias despues de comenzar el primero grado.

Por favor provea a la escuela de su nino/a uno de los siguientes:

A. Un certificado valido de examen fisico firmado por un proveedor medico. El examen debe haberse completado DENTRO DE LOS PASADOS 18 MESES.

B. Una orden firmada de renuncia voluntaria al examen de salud. (Codigo de Salud y Seguridad, Seccion 324.3)

Hasta esta fecha no tenemos archivado ni la copia del examen fisico ni la renuncia voluntaria firmada para su niño/niña. Este requisito tiene que llenarse para el o su nino seni excluido de la escuela.

Si tienen alguna pregunta, por favor llamen a la enfermera o a la encargada de salud de su escuela.

Gracias por su cooperacion en este asunto.

Sinceramente,

Ann Rector
La Directora de los Programas de Salud

APROBADO:

Dr. Shawn Bird
Chief Academic Officer

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(626) 396-3600 Ext. 88240 , Fax (626) 584-1540
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PASADENA UNIFIED SCHOOL DISTRICT
HEALTH PROGRAMS

PHYSICAL EXAMINATION REMINDER

_____
Date

Dear parents of_____,

California State Law requires that all children entering first grade have a physical examination completed within 18 months prior to entering that grade. Recently, we sent you a letter and a form to take to your health care provider or pre-paid health plan.

We have not yet received the completed form from you. If your child has had the examination, please have the doctor fill out the enclosed form and then bring it to the Health Office as soon as possible.

If your child has not had the examination, please make an appointment today and return the bottom portion of this letter to the Health Office.

We do not want to exclude your child from school because he has not had a physical examination. Please take some action on this matter now. Thank you!

Sincerely,

_____ _____ _____
School Phone # Nurse/Health Clerk

Please check No. 1 or No. 2 below, and return to Health Office, if your child has not had a physical examination yet.

1. _____My child_____has an appointment for his/her physical on:

   _____with _____
   Date Name of provider or pre-paid health plan

2. _____I do not have a provider and would like information on having the school nurse practitioner perform the examination. [This is available only to those with low incomes, Medi-Cal recipients, or for $50.00 cash payment. This is not available for children eligible for pre-paid medical plans.]

DISTRITO ESCOLAR UNIFICADO DE PASADENA
PROGRAMAS DE SALUD

RECORDATORIO DE EXAMEN FISICO

Fecha _____

Estimados Padres de_____,

La Ley del Estado de California requiere que todos los niños que estén entrando al primer grado deben de tener un examen físico dentro de los 18 meses anteriores a su entrada a ese grado. Recientemente les enviamos una carta y una forma para que la llevaran a su médico o a su plan prepagado de salud.

Todavía no hemos recibido la forma completada de parte suya. Si su niño/a ha tenido el examen físico, por favor pídale a su médico que llene la forma que va incluída y traígala a la oficina de salud tan pronto como le sea posible.

Si su niño/a no ha recibido el examen físico, por favor haga una cita con su médico ahora mismo y regrese la porción de abajo de esta carta a la Oficina de Salud.

No queremos tener que excluir a su niño/a de la escuela porque no ha tenido un examen físico. Por favor hágalo ahora. Gracias!

Atentamente,

_____	_____	_____
Escuela	Telefono	Enfermera/Ayudante

Por favor marque el número 1 ó el 2 y regrese esta forma a la Oficina de Salud, si es que todavía no le han dado a su niño/a el examen físico.

1. _____Mi niño/a_____tiene una cita para su examen físico el:

   _____con _____
   Fecha Nombre del proveedor o plan médico

2. _____No tengo proveedor y me gustaría recibir información para que la enfermera de la escuela le haga el examen. [Este es obtenible únicamente para aquellas personas que tienen ingresos bajos, que son recipientes de Medi-Cal o por el costo de $50.00 en efectivo. No es para niños que califican para los planes médicos prepagados.]

PASADENA UNIFIED SCHOOL DISTRICT
EDUCATION CENTER . HEALTH PROGRAMS

PHYSICAL EXAMINATION EXCLUSION NOTICE

To the Parents/Guardian of_____

School_____Date_____

Teacher_____

Dear Parent/Guardian:

The State of California requires that ALL FIRST GRADE STUDENTS have on file a report of a physical examination completed within 18 months before or within 90 days after entering first grade.

According to our records your child has neither a report nor a waiver for this physical examination on file. Therefore, effective_____the above named student is excluded from school until the requirement is met. We regret having to take this action.

If you have any questions, please call your school nurse or health clerk at:_____.

Sincerely,

Ann Rector
Director of Health Programs

APPROVED:

Dr. Shawn Bird
Chief Academic Officer

351 South Hudson Avenue •Pasadena, CA 91109
(626) 396-3600 Ext. 88240 , Fax (626) 584-1540
www.pusd.us

PASADENA UNIFIED SCHOOL DISTRICT
EDUCATION CENTER , HEALTH PROGRAMS

AVISO DE EXCLUSION POR EXAMEN FISICO

Al Padre/Tutor de _____

Escuela_____ Fecha_____ Maestro/a_____

Estimado Padre/Tutor:

El Estado de California requiere que TODOS LOS ALUMNOS DEL PRIMER GRADO tengan en las archivos escolares un reporte de un examen fisico completo dentro de las 18 meses antes de que entren al primer grado o dentro de 90 dias despues de haber entrado.

De acuerdo con nuestros records, su hijo/a no tiene ni un reporte ni una dispensa para el examen fisico en los archivos de la escuela. Por lo tanto, efectivo el dia el alumno nombrado arriba ser:i excluido de la escuela hasta que se cumpla con este requisito. Lamentamos tener que tomar esta accion.

Si tiene preguntas, par favor harne a la enfermera de la escuela, o a la ayudante de salud, a este numero _____

Cordialmente,

Ann Rector
La Directora de las Programas de Salud

APROBADO:

Dr. Shawn Bird
Chief Academic Officer

351 South Hudson Avenue •Pasadena, CA 91109
(626) 396-3600 Ext. 88240, Fax (626) 584-1540
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PASADENA UNIFIED SCHOOL DISTRICT
EDUCATION CENTER. HEALTH PROGRAMS

Dear Parent/Guardian,

The State of California and the Pasadena Unified School District highly recommend that your child have a complete physical examination periodically, to identify and/or prevent health problems that can interfere with successful learning. Many health problems can be corrected, or the severity reduced by prompt diagnosis and treatment. The earlier they are found, the more easily they can be treated or corrected.

If your child has not had a complete physical examination in the last 4 years, he/she may be eligible for a no-cost health assessment. If you have no health insurance, have regular Medi-Cal and are income eligible, the Pasadena Unified School District Clinic can provide your child with a complete physical exam.

Please notify your school nurse or health clerk if you desire this service, so that an appointment can be made for your child.

Sincerely,

Ann Rector
Director of Health Programs

APPROVED:

Dr. Shawn Bird
Chief Academic Officer

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PASADENA UNIFIED SCHOOL DISTRICT
EDUCATION CENTER , HEALTH PROGRAMS

Estimado Padre/Tutor:

El Estado de California y el Distrito Escolar Unificado de Pasadena altamente recomiendan que su niño tenga un examen fisico completo periodicamente, para identificar y/o para prevenir problemas de salud que puedan interferir con el exito de! aprendizaje. Se pueden corregir muchos problemas de salud, o la severidad se puede reducir por medio de diagnosis o tratamiento inmediato. Lo mas pronto que se puedan encontrar, lo mas facil que se pueden tratar o corregir.

Si su niño no ha tenido un examen fisico en los ultimos 4 años, puede ser elegible para una evaluacion de salud gratis. Si no tiene seguro de salud, tiene Medi-Cal regular y su ingreso le permite ser elegible, la Clinica del Distrito Escolar Unificado de Pasadena le puede dar a su niño un examen fisico completo.

Por favor avise a la enfermera de su escuela o a la ayudante de la enfermera si desea este servicio, para que haga una cita para su niño/a.

Cordialmente,

Ann Rector
La Directora de los Programas de Salud

APROBADO:

Dr. Shawn Bird
Chief Academic Officer

351 South Hudson Avenue •Pasadena, CA
91109 (626) 396-3600 Ext. 88240,
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www.pusd.us

Report of Health Examination for School Entry CHDP PM 171A
English & Spanish

available at:

http://www.dhcs.ca.gov/formsandpubs/forms/Forms/ChildMedSvcForms/pm171a(bi).pdf

State of California—Health and Human Services Agency

Department of Health Care Services
Child Health and Disability Prevention (CHDP) Program

WAIVER OF HEALTH EXAMINATION FOR SCHOOL ENTRY

CHILD'S NAME—Last	First	Middle	DATE OF BIRTH—Month/Day/Year

ADDRESS—Number, Street	City	ZIP Code	SCHOOL	Teacher

PARENT OR GUARDIAN:

Please fill out this form if you want to excuse your child from the health examination required by California law for school entry. ***SIGN AND RETURN THIS FORM TO THE SCHOOL*** where it will be maintained as confidential information.

NOTE: SIGNING THIS WAIVER ***DOES NOT*** EXCUSE YOUR CHILD FROM RECEIVING THE IMMUNIZATIONS REQUIRED BY CALIFORNIA LAW FOR CHILDREN IN SCHOOL. ALSO, SIGNING THIS WAIVER WILL NOT DENY YOUR CHILD THE VISION AND HEARING TESTS DONE BY THE SCHOOL.

I have been informed about the health examination recommended by health professionals and required by state law. I have been informed about where my child can receive a health examination and about the income levels for receiving it at no cost to me.

Please check one of the following:

☐ I choose not to have my child receive a health examination as part of the school entry requirement.

☐ I would like my child to receive a health examination, but I am unable to obtain it.

Reason (see Health and Safety Code, Section 124085): _____

_____

_____ _____

Signature of parent or guardian | Date

INQUIRE AT THE SCHOOL OFFICE OR YOUR LOCAL HEALTH DEPARTMENT IF YOU WANT MORE INFORMATION.
CHDP website: www.dhcs.ca.gov/services/chdp

RENUNCIA VOLUNTARIA PARA RECIBIR UN EXAMEN DE SALUD PARA INGRESAR A LA ESCUELA

NOMBRE DEL NIÑO/DE LA NIÑA—Apellido	Primer Nombre	Segundo Nombre	FECHA DE NACIMIENTO—Mes/Día/Año

DIRECCIÓN—Número/Calle	Ciudad	Zona Postal	ESCUELA	Maestro(a)

PADRE/MADRE O GUARDIÁN:

Si desea que su niño(a) no reciba el examen de salud requerido por la ley de California antes de ingresar a la escuela, por favor llene este formulario. ***FIRMELO Y DEVUELVALO A LA ESCUELA*** donde será guardado en forma confidencial.

AVISO: EL FIRMAR ESTA RENUNCIA VOLUNTARIA *NO* DISPENSA PARA QUE EL NIÑO/LA NIÑA RECIBA LAS INMUNIZACIONES REQUERIDAS POR LA LEY DE CALIFORNIA PARA LOS NIÑOS EN LA ESCUELA. TAMBIÉN, EL FIRMAR ESTE FORMULARIO NO LE NEGARÁ A SU NIÑO(A) EL DERECHO A RECIBIR LOS EXÁMENES DE LA VISTA Y EL OÍDO HECHOS POR LA ESCUELA.

Se me ha informado acerca del examen de salud recomendado por los respectivos profesionales y requerido por la ley del estado. Se me ha informado también acerca de los lugares donde mi niño(a) puede recibir un examen de salud y sobre los diferentes niveles de ingresos para recibirlo sin costo alguno.

Por favor marque uno de los siguientes casilleros:

☐ Escojo que mi niño(a) no reciba el examen de salud que es uno de los requisitos para ingresar a la escuela.

☐ Me gustaría que mi niño(a) reciba un examen de salud, pero estoy incapacitado(a) para obtenerlo.

Razón (vea Health and Safety Code, Sección 124085): _____

_____

_____ _____

Firma del padre/madre o guardián — Fecha

SI DESEA MÁS INFORMACIÓN CONSIGALA EN LA ESCUELA O EN SU DEPARTAMENTO LOCAL DE SALUD.
CHDP website: www.dhcs.ca.gov/services/chdp

SCHOOL NURSE REFERRAL TO THE CHDP PROGRAM

Date: _____

Referred by: _____ School Name: _____

School District: _____ Telephone: _____
(List days and times you can be reached at this number)

Fax Number: _____

A problem has been identified with the CHDP service provided by the CHDP Health Assessor listed below. Follow-up by a CHDP Public Health Nurse is requested.

Provider/Clinic Name: _____

Health Assessor Name _____

Address: _____
Street City Zip Code

Telephone Number: _____

Please fax to the regional office that covers the address of the provider:

North: Phone 855-272-6820 Fax: 855-871-0380
Southwest: Phone 424-338-1186 Fax: 310-223-0090
East: Phone 626-569-3750 Fax: 626-571-4580

Child's Name: Birthdate: _____ M F

Address: _____ Phone _____

Parent's Name Work Phone _____

Problem(s) found, date of service and comments (Attach PM 160/PM 161 if available):

_____

_____

_____

_____

_____

RESULTS OF FOLLOW-UP BY CHDP PHN

Date: _____

Findings and action:

_____

_____

_____

_____

_____

CHDP PHN: _____ Telephone _____

PASADENA UNIFIED SCHOOL DISTRICT
HEALTH PROGRAMS

To: Site Nurses

From: _____
Clinic Nurse Practitioner

Subject: Referral and Follow-Up

Date: _____

The following student was examined by me and health concerns requiring your assistance are noted.

Name_____School_____Grade_____D.O.B. _____

Address_____Phone _____

Parent's Work Phone _____Date of Exam _____

SCHOOL NURSE FOLLOW-UP REQUIRED

A. Problems: _____

_____

_____

_____

B. Recommendations: _____

_____

_____

_____

C. Follow-Up: _____

_____

_____

_____

D. Disposition: _____

_____

_____

_____

PLEASE RETURN TO CLINIC WHEN COMPLETED

_____
SITE NURSE

Dental Providers Who Accept Denti-Cal or Medi-Cal

Proveedores de dentales que acepta Denti-Cal o Medi-Cal

91101

Maria Cabalinan, D.D.S.
668 N. Los Robles Avenue
Pasadena, CA 91101
(626) 405-9090
Languages Spoken: Spanish, Tagalog

Century Dental Centers
115 S. Los Robles Avenue
Pasadena, CA 91101
(626) 795-8628
Languages Spoken: Spanish and Mandarin

Dental Plus
310 S. Lake Avenue
Pasadena, CA 91101
(626) 795-6855
Languages Spoken: Spanish, Armenian, Tagalog, Farsi, Burmese, Mandarin, Vietnamese, Hungarian, Arabic, French

Newport Dental
81 N. Lake Avenue
Pasadena, CA 91101
(626) 440-0240
Languages Spoken: Spanish, Armenian, Chinese, & Tagalog

Smart Dental Care
742 E. Colorado Blvd.
Pasadena, CA 91101
(626) 405-0707

Lena Zerounian, D.D.S.
65 N. Madison Avenue, Suite 701
Pasadena, CA 91101
(626) 795-2900
Languages Spoken: Spanish, Armenian, & Arabic

91103

Altadena Dental Center
2036 Lincoln Avenue
Pasadena, CA 91103
(626) 797-6555
Languages Spoken: Spanish, Russian, & Armenian

Community Health Alliance of Pasadena (CHAP)-Fair Oaks Dental Clinic
1855 N. Fair Oaks Avenue
G-Floor, Suite 100
Pasadena, CA 91103
(626) 398-5970
Languages Spoken: Spanish & Tagalog

91104

Allen and Washington Dental Office
1864 E. Washington Blvd., Suite 102
Pasadena, CA 91104
(626) 791-7474

Raffi Malkounian, D.D.S.
1330 Sinaloa Avenue, Suite 201
Pasadena, CA 91104
(626) 794-0620
Languages Spoken: Arabic, Hungarian, & Russian

Vicki Wang, D.D.S.
1282 N. Lake Avenue
Pasadena, CA 91104
(626) 797-3451
Languages Spoken: Spanish & Korean

91105

Reynaldo Barbon, D.D.S.
109 W. California Blvd.
Pasadena, CA 91105
(626) 844-7778
Languages Spoken: Spanish & Tagalog

Altina Karimyan, D.D.S.
800 Fairmont Avenue, Suite 100
Pasadena, CA 91105
(626) 304-3004
Languages Spoken: Spanish

91106

Pacita Franco, D.D.S.
324 N. Allen Avenue
Pasadena, CA 91106
(626) 795-6566
Languages Spoken: Tagalog

Karen Guinn, D.D.S.
1175 E. Green Street
Pasadena, CA 91106
(626) 578-1687
Languages Spoken: Spanish

Kids Dental Care
1127 E. Green Street
Pasadena, CA 91106
(626) 389-2570
Languages Spoken: Spanish

Walnut Hill Dental Group
181 N. Hill Avenue
Pasadena, CA 91106
(626) 796-0313
Languages Spoken: Spanish, Armenian, Russian, & Tagalog

91107

Kim Hong, D.D.S.
2379 E. Colorado Blvd.
Pasadena, CA 91107
(626) 584-7017
Languages Spoken: Spanish & Korean

Washington Dental Group
2554 E. Washington Blvd.
Pasadena, CA 91107
(626) 296-0056
Languages Spoken: Spanish

Los Angeles County

Pediatric & Family Medical Center
1530 S. Olive Street
Los Angeles, CA 90015
(213) 747-5542
Languages Spoken: Spanish

Further Information

Dental Society - (626) 285-1174
Medi-Cal - 1(800) 322-6384
PCC Dental Clinic - (626) 585-7241

PASADENA

City of Pasadena Public Health Department
Child Health & Disability Prevention (CHDP) Program
Approved Providers for Physical Exams and Medical Services By Zip Code
Proveedores aprobados para exámenes físicos y servicios médicos por código postal

91101

Raul Grover, M.D.
65 N. Madison Avenue, Suite 709
Pasadena, CA 91101
(626) 795-2110
Languages Spoken: Spanish, Hindi, Korean, & Russian

91103

AMG Medical Corporation
193 E. Orange Grove Blvd.
Pasadena, CA 91103
(626) 568-3302
Languages Spoken: Spanish & Vietnamese

Community Health Alliance of Pasadena (CHAP)-Fair Oaks
1855 N. Fair Oaks Avenue
Pasadena, CA 91103
(626) 398-6300
Languages Spoken: Spanish

Carlos Rodriguez, M.D.
1403 N. Fair Oaks Avenue, Suite 1
Pasadena, CA 91103
(626) 398-0354
Languages Spoken: Spanish

91104

Bill Moore Health Clinic URDC Human Services Corp.
1460 N. Lake Avenue, Suite 107
Pasadena, CA 91104
(626) 398-3796
Languages Spoken: Spanish, Armenian, & Russian

Family First Medical Group
456 E. Orange Grove, Suite 120
Pasadena, CA 91104
(626) 683-8818
Languages Spoken: Spanish, Cantonese, Tagalog, & Mandarin

Nubar Sethian, M.D.
1028 N. Lake Avenue, Suite 103
Pasadena, CA 91104
(626) 797-3378
Languages Spoken: Spanish, Arabic, Armenian, & Farsi

91105

Oluyemisi Afuape, M.D.
50 Alessandro Place, Suite 100
Pasadena, CA 91105
(626) 792-0717
Languages Spoken: Spanish

Audrey Reid, M.D.
800 Fairmont Avenue, Suite 110
Pasadena, CA 91105
(626) 795-7051
Languages Spoken: Spanish

Modern Concepts
50 Bellefontaine Street, Suite 401
Pasadena, CA 91105
(626) 793-1931
Languages Spoken: Spanish

PUSD-Education Center Clinic
351 S. Hudson Avenue, Room 130
Pasadena, CA 91105
(626) 396-3600 x88180
Languages Spoken: Spanish & Armenian

91107

Crown City Medical Group
2661 E. Washington Blvd.
Pasadena, CA 91107
(626) 798-4952
Languages Spoken: Spanish

Community Health Alliance of Pasadena (CHAP)-Del Mar
3160 Del Mar Blvd.
Pasadena, CA 91107
(626) 389-8715
Languages Spoken: Spanish

Issac Haddad, M.D.
2990 E. Colorado Blvd., Suite 105C
Pasadena, CA 91107
(626) 793-3700
Languages Spoken: Spanish, Armenian, French, & Arabic

Pasadena CHDP Office
1845 N. Fair Oaks Ave, Room 1136
Pasadena, CA 91103
(626) 744-6016 or (626) 744-6168

Revised 09/2013

PERIODICITY SCHEDULE FOR HEALTH ASSESSMENT REQUIREMENTS BY AGE GROUPS

Screening Requirement	Age of Person Being Screened														
	Under 1 mo	1 - 2 mos	3 - 4 mos	5 - 6 mos	7 - 9 mos	10-12 mos	13-15 mos	16-23 mo	2 Yr	3 Yr	4 - 5 Yr	6 - 8 Yr	9 - 12 Yr	13-16 Yr	17-20 Yr
Interval Until Next Exam	1 mo	2 mo	2 mo	2 mo	3 mo	3 mo	3 mo	6 mo	1 yr	1 yr	2 yr	3 yr	4 yr	4 yr	None
History and Physical Examination	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦
Dental Assessment	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦
Nutritional Assessment	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦
Developmental/Behavioral	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦
Anticipatory Guidance	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦
Tobacco Assessment	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦
Pelvic Exam 1														♦	♦
Measurements															
Head Circumference	♦	♦	♦	♦	♦	♦	♦	♦							
Height/Length and Weight	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦
Blood Pressure										♦	♦	♦	♦	♦	♦
Sensory Screening															
Visual Acuity Test (Snellen) 2										♦	♦	♦	♦	♦	♦
Clinical Observation	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦
Audiometric 2										♦	♦	♦	♦	♦	♦
Non-audiometric	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦
Procedures/Tests															
Tuberculin Test											♦			♦	
TB Exposure Risk Assessment	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦
Hematocrit or Hemoglobin					♦		♦		♦	♦	♦	♦	♦	♦	♦
Urine Dipstick or Urinalysis											♦	♦	♦	♦	♦
Blood Lead Test						♦			♦						
Blood Lead Risk Assessment				♦	♦	♦	♦	♦	♦	♦	♦				
Other Laboratory Tests															
VDRL, RPR, or ART	To be done when health history and/or physical examination warrants.														
Gonorrhea Test	To be done when health history and/or physical examination warrants.														
Chlamydia Test	To be done when health history and/or physical examination warrants.														
Papanicolaou (Pap) Smear	To be done when health history and/or physical examination warrants.														
Sickle Cell	To be done when health history and/or physical examination warrants.														
Ova and Parasites	To be done when health history and/or physical examination warrants.														
Immunizations	Administer as necessary to make status current.														

Note: Children coming under care who have not received all the recommended procedures for an earlier age should be brought up-to-date as appropriate.

1. Recommended for sexually active females and females age 18 years and older.
2. Snellen testing and audiometric testing should start at age 3 years if possible. Clinical observation and nonaudiometric testing may be substituted if child is uncooperative.

CHILD HEALTH AND DISABILITY PREVENTION PROGRAM

When parents/guardians enroll their children in kindergarten, the district shall inform them about their obligation to obtain or waive a health screening for their children before they enter first grade. The district shall also inform them about the availability of free health screening for low- income children, as provided under the Child Health and Disabilities Prevention Program, and about the evaluation services and other benefits provided under Division 106, Part 2, Chapter 3, Article 6 of the Health and Safety Code. (Health and Safety Code 124100, 124105)

The above information shall be provided with notifications about immunization requirements and when parents/guardians enroll any first grade children who have not attended kindergarten in the district. The district shall encourage parents/guardians to arrange for their children to obtain their health screening prior to or during their kindergarten year.

(cf. 5141.31 - Immunizations)

The Superintendent or designee may arrange for local health authorities to offer health examinations at school sites.

(cf. 1020 - Youth Services)

During the first 90 days of school, the Superintendent or designee may contact any first grade parents/guardians who have not provided evidence of a health screening or a waiver. If any parents/guardians do not respond to this notification, the Superintendent or designee may contact them a second time to ensure that they understand that their children may be eligible to receive a health screening at no cost.

The Board shall exclude from school, for up to five days, any first grade student who does not present evidence of a health screening or an appropriate waiver on or before the 90th day after entering the first grade. This exclusion shall begin on the 91st calendar day after the student's entrance into the first grade. If school is not in session that day, the exclusion shall begin on the next succeeding schoolday. Within limits established in law, the Superintendent or designee may exempt from exclusion students whose parents/guardians failed to respond to district attempts to obtain evidence of health screening or a signed waiver.
(Health and Safety Code 124105)

(cf. 5112.2 - Exclusions from Attendance)

CHILD HEALTH AND DISABILITY PREVENTION PROGRAM (continued)

The Superintendent or designee shall annually provide the county Child Health and Disability Prevention Program, the State Department of Health Services and the California Department of Education with the health screening information required by law. (Health and Safety Code 124200)

Legal Reference:

HEALTH AND SAFETY CODE
104395 Child Health and Disability Prevention Program expansion,
120425-124100 Child Health Disability Prevention Program, especially
1240402 Establishment of programs; standards for procedures
124085 Certificate of receipt; health screening and evaluation services; waiver by parent or guardian
124100 School districts and private schools; information to parents or guardians of kindergarten children
124105 Hughes Children's Health Enforcement Act

SCHOOL-BASED HEALTH AND SOCIAL SERVICES

Inasmuch as good physical and mental health is critical to students' ability to learn, the Governing Board believes that all students should have access to comprehensive health and social services. The Board desires to collaborate with local health, mental health and social service providers in order to offer integrated services at or near district schools.

(cf. 1020 - Youth Services)

The district may provide preventive, diagnostic, therapeutic and/or rehabilitative health services on an outpatient basis at school sites. The district shall serve as a Medi-Cal provider to the extent feasible and shall comply with all related legal requirements.

(cf. 5131.6 - Alcohol and Other Drugs)
(cf. 5141.21 - Administering Medication)
(cf. 5141.24 - Specialized Health Care Services)
(cf. 5141.25 - Availability of Condoms)
(cf. 5141.26 - Tuberculosis Testing)
(cf. 5141.3 - Health Examinations)
(cf. 5141.31 - Immunizations)
(cf. 6159 - Individualized Education Program)
(cf. 6164.6 - Identification and Education under Section 504)

Legal Reference:
EDUCATION CODE
8800-8807 Healthy Start support services for children
49423.5 Specialized physical health care services
CODE OF REGULATIONS, TITLE 22
51051 Providers of services
Local educational agency eligible beneficiary
Local educational agency provider
Local educational agency practitioner
Local educational agency services
Managed care plan
51270 Local educational agency provider; conditions for participation
51360 Local educational agency; types of services
51491 Local educational agency eligibility for payment
51535.5 Reimbursement to local educational agency providers

Management Resources:
CDE PUBLICATIONS
LEA Medi-Cal Billing Option, 4/25/94

Policy **PASADENA UNIFIED SCHOOL DISTRICT**
adopted: November 14, 1995 Pasadena, California

SCHOOL-BASED HEALTH AND SOCIAL SERVICES

The following services may be provided by the district:

1. Health and mental health evaluation and education, including:

   a. Nutritional assessment and non-classroom nutrition education (diet, feeding, laboratory values and growth).

   b. Vision assessment consisting of examination of visual acuity at the far point conducted by the Snellen Test.

   c. Hearing assessment consisting of test for auditory impairment using at-risk criteria and appropriate screening techniques as defined in Title 17, Section 2951(c).

   d. Developmental assessment consisting of review of developmental achievement in comparison with expected norms for age and background.

   e. Assessment of psychosocial status consisting of appraisal of cognitive, emotional, social and behavioral functioning and self-concept through tests, interviews and behavioral evaluations.

   f. Health education and guidance appropriate to age and health status, consisting of non-classroom health education and anticipatory guidance based on age and developmentally appropriate health education.

(cf. 5141.3 - Health Examinations)

2. Physical therapy services as set out in Title 22, Section 51309(b).

3. Occupational therapy services as set out in Title 22, Section 51309(c).

4. Speech pathology services as defined in Title 22, Section 51096 and audiology services as defined in Title 22, Section 51098.

5. Psychology and counseling services consisting of diagnosis and psychological counseling of identified mental health, substance abuse, behavioral adjustment or social problems.

(cf. 5131.6 - Alcohol and Other Drugs)

6. Preventive and medically necessary nursing services rendered at the school site, and services for accompanying the student off-campus for

SCHOOL-BASED HEALTH AND SOCIAL SERVICES (continued)

health services specified as medically necessary in the individual's Individualized Education Program (IEP), Individualized Family Service Plan (IFSP), or Individualized Health and Support Plan (IHSP).

(cf. 5141.26 - Tuberculosis Testing)
(cf. 5141.31 - Immunizations)
(cf. 6159 - Individualized Education Program)

7. School health aide services consisting of the direct provision of specialized physical health care services at the school site, and services for accompanying the student off-campus for health services specified as medically necessary in the individual's IEP, IFSP or IHSP.

(cf. 5141.24 - Specialized Health Care Services)

8. Medical transportation and associated mileage as described in Title 22, Section 51323(a) and 51360(b).

9. Other services which may not be funded by Medi-Cal.

Health care aides who provide specialized physical health care services pursuant to Education Code 49423.5 shall be under the supervision of a licensed physician and surgeon, a registered credentialed school nurse, or a certified public health nurse. All other individuals performing health and social services shall provide documented evidence of being licensed, certified, registered or otherwise credentialed to practice in California. They shall provide only those services which are within their appropriate scope of practice. (Title 22, Section 51190.3, 51270, 51491)

(cf. 5141.32 - Child Health and Disability Prevention Program)