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Section VI – School-Based Health Clinics

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School Based Health Clinic Guidelines

The primary goal of the School Based Health Clinic is to keep students in school and help them realize their full potential. The School based health clinic plays an important role in helping families manage the physical and mental health care needs of their children. In addition to the important benefit of keeping parents in the workplace, the clinic strengthens the connection between school and the family so that they can work together more effectively to meet a child's educational needs. This important resource also helps to address the health care needs of underserved and uninsured children in the Pasadena area.

Our objectives are to provide comprehensive health assessments, screening, and preventive screening, including anticipatory guidance, reduce substance abuse/high risk behavior, and increase family involvement in behavioral health problems.

Clinical services are furnished by an integrated, interagency team consisting of Physician consultants, Pediatric and Family Nurse Practitioners, School Nurses, School Social Workers, School Psychologists, Licensed mental Health Therapists, and a Certified Substance Abuse Counselor. Services include Child Health & Disability Prevention Physical examinations, well child care and immunizations, routine lab tests, care for acute illness and injury, prescription medications such as antibiotics, care of stable chronic conditions, mental health services, and student health education. Drug, alcohol, and tobacco prevention, education assessment, and counseling are available to high school students. Further services are provided in conjunction with community agencies such as the Pasadena Public Health Department and Young & Healthy.

SCHOOL HEALTH SERVICES

The Governing Board recognizes that good physical and mental health is critical to a student's ability to learn and believes that all students should have access to comprehensive health services. The district may provide access to health services at or near district schools through the establishment of a school health center and/or mobile van(s) that serve multiple campuses**.**

The Board and the Superintendent or designee shall collaborate with local and state agencies and health care providers to assess the health needs of students in district schools and the community. Based on the results of this needs assessment and the availability of resources, the Superintendent or designee shall recommend for Board approval the types of health services to be provided by the district.

(cf. 5131.6 - Alcohol and Other Drugs)
(cf. 5131.61 - Drug Testing)
(cf. 5131.62 - Tobacco)
(cf. 5131.63 - Steroids)
(cf. 5141 - Health Care and Emergencies)
(cf. 5141.21 - Administering Medication and Monitoring Health Conditions)
(cf. 5141.22 - Infectious Diseases)
(cf. 5141.23 - Asthma Management)
(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. 5141.32 - Health Screening for School Entry)
(cf. 5141.33 - Head Lice)
(cf. 5141.4 - Child Abuse Prevention and Reporting)
(cf. 5141.52 - Suicide Prevention)
(cf. 6145.2 - Athletic Competition)
(cf. 6159 - Individualized Education Program)
(cf. 6164.6 - Identification and Education under Section 504)

Board approval shall be required for any proposed use of district resources and facilities to support school health services. The Superintendent or designee shall identify funding opportunities available through grant programs, private foundations, and partnerships with local agencies and organizations.

(cf. 1260 - Educational Foundation)
(cf. 1330.1 - Joint Use Agreement)
(cf. 3100 - Budget)
(cf. 7000 - Facilities Master Plan)

The Board may prioritize school health services to schools with the greatest need, including schools with medically underserved populations, a high percentage of low-income and uninsured children and youth, large numbers of English learners, Academic Performance Index rankings in deciles 1-3, and/or a shortage of health professionals in the community.

School health services shall be provided or supervised by a licensed health care professional. The Board may employ or contract with health care professionals or partner with community health centers to provide the services under the terms of a written contract or memorandum of understanding.

(cf. 1020 - Youth Services)
(cf. 3312 - Contracts)

If a school nurse is employed by the school or district, he/she shall be involved in planning and implementing the school health services as appropriate.

The Superintendent or designee shall coordinate the provision of school health services with other student wellness initiatives, including health education, nutrition and physical fitness programs, and other activities designed to create a healthy school environment. The Superintendent or designee shall encourage joint planning and regular communications among health services staff, district administrators, teachers, counselors, other staff, and parents/ guardians.

(cf. 3550 - Food Service/Child Nutrition Program)
(cf. 5030 - Student Wellness)
(cf. 6142.7 - Physical Education and Activity)
(cf. 6142.8 - Comprehensive Health Education)
(cf. 6164.2 - Counseling/Guidance Services)

Consent and Confidentiality

The Superintendent or designee shall obtain written parent/guardian consent prior to providing services to a student, except when the student is authorized to consent to the service pursuant to Family Code 6920-6929, Health and Safety Code 124260, or other applicable law.

The Superintendent or designee shall maintain the confidentiality of student health records in accordance with law.

(cf. 5125 - Student Records)

Payment/Reimbursement for Services

The Board desires that costs not be a barrier to student access to services. Services may be provided free of charge or on a sliding scale in accordance with law.

The Superintendent or designee shall establish procedures for billing public and private insurance programs and other applicable programs for reimbursement of services as appropriate.

(cf. 5143 - Insurance)

The district shall serve as a Medi-Cal provider to the extent feasible, comply with all related legal requirements, and seek reimbursement of costs to the extent allowed by law.

To further encourage student access to health care services, the Superintendent or designee shall develop and implement outreach strategies to increase enrollment of eligible students from low- to moderate-income families in affordable, comprehensive state or federal health coverage programs and local health initiatives. Such strategies may include, but not be limited to, providing information about the Medi-Cal program on the application for free and reduced-price meals in accordance with law and providing students and parents/guardians with information about the low-cost Healthy Families insurance program.

(cf. 3553 - Free and Reduced Price Meals)

Program Evaluation

In order to continuously improve school health services, the Board shall evaluate the effectiveness of such services and the extent to which they continue to meet student needs.

The Superintendent or designee shall provide the Board with annual reports that may include, but not necessarily be limited to, rates of participation in school health services; changes in student outcomes such as school attendance or achievement; feedback from staff and participants regarding program accessibility and operations, including accessibility to low-income and linguistically and culturally diverse students and families; and program costs and revenues.

(cf. 0500 - Accountability)

Legal Reference:

EDUCATION CODE
8800-8807 - Healthy Start support services for children
49073-49079 - Privacy of student records
49423.5 - Specialized physical health care services
49557.2-49558 - Eligibility for free and reduced-price meals; sharing information with Medi-Cal
FAMILY CODE
6920-6929 - Consent by minor for medical treatment
GOVERNMENT CODE
95020 - Individualized family service plan
HEALTH AND SAFETY CODE
104830-104865 - School-based application of fluoride or other tooth decay-inhibiting agent

121020 - HIV/AIDS testing and treatment; parental consent for minor under age 12
123110 - Minor's right to access health records
123115 - Limitation on parent/guardian access to minor's health records
123800-123995 - California Children's Services Act
124025-124110 - Child Health and Disability Prevention Program 124172-
124174.6 - Public School Health Center Support Program 124260 - Mental health services; consent by minors age 12 and older
130300-130317 - Health Insurance Portability and Accountability Act (HIPAA)
WELFARE AND INSTITUTIONS CODE
14059.5 - Definition of "medically necessary"
14100.2 - Confidentiality of Medi-Cal information
14115 - Medi-Cal claims process
14124.90 - Third-party health coverage
14132.06 - Covered benefits; health services provided by local educational agencies
14132.47 - Administrative claiming process and targeted case management
CODE OF REGULATIONS, TITLE 10
2699.6500-2699.6905 - Healthy Families Program
CODE OF REGULATIONS, TITLE 17
2951 - Testing standards for hearing tests
6800-6874 - Child Health and Disability Prevention Program
CODE OF REGULATIONS, TITLE 22
51009 - Confidentiality
51050-51192 - Definitions of Medi-Cal providers and services
51200 - Requirements for providers
51231.2 - Wheelchair van requirements
51270 - Local educational agency provider; conditions for participation
51304 - Limitations on specified benefits
51309 - Psychology, physical therapy, occupational therapy, speech pathology, audiological services
51323 - Medical transportation services 51351 -
Targeted case management services
51360 - Local educational agency; types of services 51491 -
Local educational agency eligibility for payment
51535.5 - Reimbursement to local educational agency providers
UNITED STATES CODE, TITLE 20
1232g - Family Educational and Privacy Rights Act (FERPA)
UNITED STATES CODE, TITLE 42
1320c-9 - Prohibition against disclosure of records
1397aa-1397jj - State Children's Health Insurance Program
CODE OF FEDERAL REGULATIONS, TITLE 42
431.300 - Use and disclosure of information on Medicaid applicants and recipients
CODE OF FEDERAL REGULATIONS, TITLE 45
164.500-164.534 - Health Insurance Portability and Accountability Act (HIPAA)

Management Resources:
CSBA

PUBLICATIONS

Expanding Access to School Health Services: Policy Considerations for Governing Boards, Policy Brief, November 2008

Promoting Oral Health for California's Student: New Role, New Opportunities for Schools, Policy Brief, November 2008

Providing School Health Services in California: Perceptions, Challenges and Needs of District Leadership Teams, 2008

CALIFORNIA DEPARTMENT OF EDUCATION PUBLICATIONS

Health Framework for California Public Schools, Kindergarten Through Grade Twelve, 2003

CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES PUBLICATIONS

LEA Medi-Cal Provider Manual

California School-Based Medi-Cal Administrative Activities Manual

DEPARTMENT OF HEALTH SERVICES POLICY LETTERS

00-06 Managed Care Plan Relationships with Local Education Agency Providers, December 11, 2000

NATIONAL ASSEMBLY ON SCHOOL-BASED HEALTH CARE PUBLICATIONS

A Guidebook for Evaluating School-Based Health Centers

NATIONAL CENTER FOR YOUTH LAW PUBLICATIONS

Minor Consent, Confidentiality, an Child Abuse Reporting in California, October 2006

WEB SITES

CSBA: http://www.csba.org

CSBA, PractiCal Program: http://www.csba.org/Services/Services/DistrictServices/PractiCal.aspx

California County Superintendents Educational Services Association: http://www.ccsesa.org

California Department of Education, Health Services and School Nursing: http://www.cde.ca.gov/ls/he/hn

California Department of Health Care Services: http://www.dhcs.ca.gov

California Department of Public Health: http://www.cdph.ca.gov California School Health Centers Association: http://www.schoolhealthcenters.org

California School Nurses Organization: http://www.csno.org

Center for Health and Health Care in Schools: http://www.healthinschools.org

Centers for Disease Control and Prevention, School Health Policies and Programs (SHPPS) Study: http://www.cdc.gov/HealthyYouth/shpps Centers for Medicare and Medicaid Services: http://www.cms.hhs.gov Healthy Families Program: http://www.healthyfamilies.ca.gov

National Assembly on School-Based Health Care: http://www.nasbhc.org

National Center for Youth Law: http://www.youthlaw.org

Types of Health Services

In accordance with student and community needs and available resources, school health services offered by the district may include, but are not limited to:

1. Physical examinations, immunizations, and other preventive medical services

(cf. 5141.26 - Tuberculosis Testing) (cf. 5141.3 - Health Examinations) (cf. 5141.31 - Immunizations)
(cf. 5141.32 - Health Screening for School Entry)

2. First aid and administration of medications

(cf. 5141.21 - Administering Medication and Monitoring Health Conditions)

3. Diagnosis and treatment of minor injuries and acute medical conditions

4. Management of chronic medical conditions

(cf. 5141.23 - Asthma Management)

5. Basic laboratory tests

6. Referral to and follow-up for specialty care

7. Emergency response procedures

(cf. 5141 - Health Care and Emergencies)

8. Nutrition services

(cf. 3550 - Food Service/Child Nutrition Program)
(cf. 5030 - Student Wellness)

9. Oral health services that may include preventive services, basic restorative services, and referral to specialty services

The Superintendent or designee shall notify all parents/guardians of the opportunity pursuant to Health and Safety Code 104830-104865 for their child to receive the topical application of fluoride, including fluoride varnish, or other decay-inhibiting agent to the teeth during the school year. This notification may be returned by the parent/guardian to consent to the treatment or to indicate that the student shall not receive treatment because he/she has received the treatment from a dentist or the treatment is not desired. (Health and Safety Code

104830, 104850, 104855)

(cf. 5145.6 - Parental Notifications)

10. Mental health services, which may include assessments, crisis intervention, counseling, treatment, and referral to a continuum of services including emergency psychiatric care, community support programs, inpatient care, and outpatient programs

(cf. 1020 - Youth Services)
(cf. 5141.52 - Suicide Prevention)
(cf. 6164.2 - Counseling/Guidance Services)

11. Substance abuse prevention and intervention services

(cf. 5131.6 - Alcohol and Other Drugs) (cf. 5131.62 - Tobacco)
(cf. 5131.63 - Steroids)

12. Reproductive health services

(cf. 5141.25 - Availability of Condoms)

13. Screening of students to identify the need for physical, mental, and oral health services

14. Referrals and linkage to services not offered on-site

15. Public health and disease surveillance

16. Individual and family health education

17. School or districtwide health promotion

Medi-Cal Billing

In order to provide services as a Medi-Cal provider, the district shall enter into and maintain a contract with the California Department of Health Care Services (DHCS). (Welfare and Institutions Code 14132.06; 22 CCR 51051, 51270)

The Superintendent or designee shall ensure that all practitioners employed by or under contract with the district possess the appropriate license, certification, registration, or credential and provide only those services that are within their scope of practice. (22 CCR 51190.3, 51270, 51491)

The Superintendent or designee shall submit a claim for Medi-Cal reimbursement whenever the district provides a covered preventive, diagnostic, therapeutic, or rehabilitative service specified in 22 CCR 51190.4 or 51360 to a Medi-Cal-eligible student under age 22 and/or a

member of his/her family. (Welfare and Institutions Code 14132.06; 22 CCR 51096, 51098, 51190.1,

51190.4, 51309, 51360, 51535.5)

(cf. 5141.24 - Specialized Health Care Services) (cf. 6159 - Individualized Education Program)

The district shall maintain records and supporting documentation including, but not limited to, records of the type and extent of services provided to a Medi- Cal beneficiary in accordance with law. (22 CCR 51270, 51476)

(cf. 3580 - District Records) (cf. 5125 - Student Records)

The Superintendent or designee shall submit an annual report to DHCS identifying participants in the community collaborative, containing a financial summary including reinvestment expenditures, and describing service priorities for the future. (22 CCR 51270)

Any federal funds received by the district as reimbursement for the costs of services under the Medi-Cal billing option shall be reinvested in services for students and their families as specified in Education Code 8804(g). The Superintendent or designee shall consult with a local school-linked services collaborative group, such as that defined in Education Code 8806, regarding decisions on reinvestment of federal funds. (22 CCR 51270)

Medi-Cal Administrative Activities

Designated school staff shall document, on a time survey form, the amount of time spent on activities identified by DHCS which are related to the administration of the Medi-Cal program. Such activities include, but are not be limited to, outreach, referral of health and mental health services, translation services, facilitation of applications, scheduling and arranging emergency and medical transportation of eligible individuals, contracting for services, program planning and policy development, claims administration, and general administration.

The Superintendent or designee shall, on a quarterly basis, submit an invoice to the local educational consortium or local governmental agency through which the district has contracted to receive reimbursement.

Staff responsible for completing the time survey shall annually participate in training regarding eligible activities and the time survey methodology, and shall receive additional training whenever there are changes or updates in administrative claiming categories and activities. New or reassigned staff shall receive training before beginning their duties completing time surveys.

The Superintendent or designee shall maintain an audit file containing original time survey documentation and other records specified by DHCS. Such documentation shall be kept for three years after the end of the quarter in which expenditures were incurred or, if an audit is in progress, until the completion of the audit.

AVAILABILITY OF CONDOMS

The Governing Board recognizes that, according to research, many youth are engaging in sexual activity, and that such behavior can lead to increased risk of Human Immunodeficiency Virus (HIV) infection and Acquired Immune Deficiency Syndrome (AIDS), other sexually transmitted diseases, and pregnancy.

The Board strongly encourages abstaining from sexual activity. However, the Board also believes it has a responsibility to take steps to prevent the spread of disease among students who do not abstain from sexual activity.

(cf. 6142.2 - AIDS Prevention Instruction)

Condoms, when properly used, can lessen the chances of transmitting HIV and other sexually transmitted diseases. The Board therefore finds it appropriate for condoms to be available to male and female students at high schools, along with information which stresses that abstinence is the only sure means of protecting against HIV, explain the effective use of condoms, and identifies unlawful sexual activity.

The Superintendent or designee shall notify parents/guardians of Board policy regarding the availability of condoms and shall seek parent/guardian involvement in developing plans for implementing this policy. The Board shall approve plans related to the availability of condoms prior to implementation.

Only licensed health care professional authorized by the Superintendent or designee may provide condoms to individual students in accordance with restriction specified in administrative regulations.

(cf. 5141.6 - School Based Health and Social Services)

Before implementing a condom availability program, the district shall notify parents/guardians that they may exclude their children from the program. Parents/guardians who choose to exclude their children shall be offered information and educational materials designed to help them communicate effectively with their children about HIV/AIDS.

Legal Reference:

EDUCATION CODE
49062 Records; establishment, maintenance and destruction
49069 Absolute right to access
49422 Supervision of health and physical development o students
51201.5 AIDS prevention instruction
FAMILY CODE
6925 Prevention or treatment of pregnancy
HEALTH AND SAFETY CODE
199.46 Further findings and declaration
PENAL CODE
261.5 Unlawful sexual intercourse with female under age 18

286 Sodomy
288 Lewd or lascivious acts with child under age 14
288a Oral copulation
People v Beeman (1984) 35 Cal. 3d 547, 561

AVAILABILITY OF CONDOMS

Any district health care professional who furnishes condoms to students and/or provides related counseling shall:

1. Explain that abstinence is the only 100% effective method of preventing pregnancy and sexually transmitted diseases.

2. Advise the student not to engage in unlawful sexual activity. Explain that state law prohibits a male of any age from having sexual intercourse with a female under 18 to whom he/she is not married and that other state laws prohibit other kinds of sexual activity with minors.

3. Refrain from condoning or in any way encouraging sexual activity among or with minors.

4. Ensure that the condoms are provided in their original packaging, along with the manufacturer's instructions.

5. Give the student advice, both oral and written, on the proper use of condoms and their effectiveness.

6. Maintain a confidential list of parental exclusions, and check this list to be sure that student seeking condoms have not been excluded by their parents/guardians.

No record shall be kept of students who receive condoms.

Written Information

Wherever condoms are made available, the following written information shall also be available:

1. A statement that abstinence is the only 100% effective method of preventing pregnancy and sexually transmitted diseases.

2. An explanation of state law:

   a. That prohibits a male of any age from having sexual intercourse with a female under 18 to whom he is not married, and

   b. That prohibits other kinds of sexual activity with minors.

3. Manufacturer's instructions on the proper use of condoms.

AVAILABILITY OF CONDOMS (continued)

4. Information on the effectiveness of condoms.

5. Addresses and telephone numbers of resources that provide further information and counseling regarding HIV testing, AIDS and other sexually transmitted diseases.

Pasadena Unified School District
Health Programs

351 South Hudson Avenue • Pasadena, CA 91109

VACCINE ADMINISTRATION RECORD

I have been given and have read, or have had explained to me, the information contained in the "Vaccine Information Statement(s)" about the disease(s) and vaccine(s) indicated below. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) and request that the vaccine(s) indicated below be given to me or to the person named below for whom I am authorized to make this request.

Me han dado una copia y he leido, o me han explicado la información contenida en el "Folleto de Información Sobre las Vacunas" sobre las enfermedades y vacunas indicadas abajo. He tenido oportunidad de hacer preguntas, las que me han sido contestadas a mi completa satisfación. Creo que entiendo los beneficios y los riesgos de las vacunas y pido que estas vacunas me sean aplicadas a mi o la persona cuyo nombre aparece abajo por quien estoy autorizado para hacer esta solicitud.

Vaccine	Date Given	Age	Manufacturer & Lot Number	Site/ Route	Administered by	Authorized Signature	Date Signed	VIS Rev. Date
IPV □ OPV □	/ /						/ /	/ /
□ □	/ /						/ /	/ /
□ □	/ /						/ /	/ /
□ □	/ /						/ /	/ /
□ □	/ /						/ /	/ /
DTP □ DT □ Td □ DTaP □	/ /						/ /	/ /
□ □ □ □	/ /						/ /	/ /
□ □ □ □	/ /						/ /	/ /
□ □ □ □	/ /						/ /	/ /
□ □ □ □	/ /						/ /	/ /
□ □ □ □	/ /						/ /	/ /
HibT □ PedV □ ProH □	/ /						/ /	/ /
□ □ □	/ /						/ /	/ /
□ □ □	/ /						/ /	/ /
□ □ □	/ /						/ /	/ /
MMR □ MR □ M □	/ /						/ /	/ /
□ □ □	/ /						/ /	/ /
HBV	/ /						/ /	/ /
	/ /						/ /	/ /
	/ /						/ /	/ /
Varicella	/ /						/ /	/ /
	/ /						/ /	/ /
Hepatitis A	/ /						/ /	/ /
	/ /						/ /	/ /
PCV 7	/ /						/ /	/ /
	/ /						/ /	/ /
	/ /						/ /	/ /
	/ /						/ /	/ /
Other	/ /						/ /	/ /

TB Skin Tests	Date Given	Given by	Date Read	Read by	mm indur	Impression	Authorized Signature
PPD-Mantoux	/ /		/ /				
PPD-Mantoux	/ /		/ /				

VFC Status: This patient □ is □ is not qualified to receive VFC vaccine (check reason below if qualified).

□ CHDP/Medi-Cal □ No Insurance

□ Am. Indian/Alaskan Native □ Insurance does not cover vaccines

Patient's Name, Record Number and Date of Birth

Name: _____

Birth Date: _____ School: _____

Address: _____

Telephone #: (H) _____ (Cell) _____

School ID #: _____

H-519 (rev 4/2003) See Reverse Side for Instructions

Pasadena Unified School District
Health Programs
351 South Hudson Avenue • Pasadena, CA 91109

NAME (last) _____ (first) _____ DOB _____

VACCINE ADMINISTRATION RECORD

Screening Questionnaire for Child and Teen Immunization
Cuestionario de la Vacunación de Niño y Adolescentes

For parents/guardians: The following questions will help us determine which vaccines may be given today. If a question is not clear, please ask the nurse to explain it.

Destinado a los padres/tutores: Las siguientes preguntas nos ayudarán a determinar cuales vacunas pudieran ser dadas hoy. Si alguna pregunta no le quedara clara, faver de pedirle a la enfermera que se la explique.

	Date/Fecha	Date/Fecha	Date/Fecha	Date/Fecha
1. Is the child sick today? ¿Está enfermo(a) el niño(a) hoy?	Y ☐ N ☐ ? ☐	Y ☐ N ☐ ? ☐	Y ☐ N ☐ ? ☐	Y ☐ N ☐ ? ☐
2. Does the child have allergies to medications, food, or any vaccine? ¿El niño(a) es alérgico(a) a medicamentos, alimentos o alguna vacuna?	Y ☐ N ☐ ? ☐	Y ☐ N ☐ ? ☐	Y ☐ N ☐ ? ☐	Y ☐ N ☐ ? ☐
3. Has the child had a serious reaction to a vaccine in the past? ¿El niño(a) ha tenido en el pasado una reacción grave a alguna vacuna?	Y ☐ N ☐ ? ☐	Y ☐ N ☐ ? ☐	Y ☐ N ☐ ? ☐	Y ☐ N ☐ ? ☐
4. Has the child had a seizure or a brain problem? ¿El niño(a) ha sufrido algún ataque convulsivo o algún problema cerebral?	Y ☐ N ☐ ? ☐	Y ☐ N ☐ ? ☐	Y ☐ N ☐ ? ☐	Y ☐ N ☐ ? ☐
5. Does the child have cancer, leukemia, AIDS, or any other immune system problem? ¿El niño(a) padece de cáncer, leucemia, SIDA, o alguna otra deficiencia del sistema inmunológico?	Y ☐ N ☐ ? ☐	Y ☐ N ☐ ? ☐	Y ☐ N ☐ ? ☐	Y ☐ N ☐ ? ☐
6. Has the child taken cortisone, prednisone, other steroids, or anticancer drugs, or had x-ray treatments in the past 3 months? ¿Durante los últimos 3 meses, el niño(a) ha consumido cortisona, prednisona, otras esteroides o drogas contra el cáncer, o ha recibido tratamientos con radiografías?	Y ☐ N ☐ ? ☐	Y ☐ N ☐ ? ☐	Y ☐ N ☐ ? ☐	Y ☐ N ☐ ? ☐
7. Has the child received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin in the past year? ¿Ha recibido el niño(a) una transfusión de sangre o plasma, o ha recibido un medicamento llamado "gamaglobulina inmunológica" durante el ultimo año?	Y ☐ N ☐ ? ☐	Y ☐ N ☐ ? ☐	Y ☐ N ☐ ? ☐	Y ☐ N ☐ ? ☐
8. Is the child/teen pregnant or is there a chance she could become pregnant in the next 3 months? ¿Su hija, o su adolescente, está embarazada o existe la posibilidad de que se embarace en los próximos 3 meses?	Y ☐ N ☐ ? ☐	Y ☐ N ☐ ? ☐	Y ☐ N ☐ ? ☐	Y ☐ N ☐ ? ☐
9. Has the child received any vaccinations in the past 4 weeks? ¿En las últimas 4 semanas, el niño(a) ha sido vacunado(a)?	Y ☐ N ☐ ? ☐	Y ☐ N ☐ ? ☐	Y ☐ N ☐ ? ☐	Y ☐ N ☐ ? ☐

Adapted from Immunization Action Coalition (3/01)

Site of Administration		Routes of Administration:
LD = Left Deltoid	**LT** = Left Thigh	**IM** – Dtap, DT, Td, Hib, HBV, HBV/HIB, Hep A, PCV 7
RD = Right Deltoid	**RT** = Right Thigh	**SC** – MMR, MR, M, IPV, Varicella

I have read and understand the disclosure to parent/guardian on the **Los Angeles Regional Immunization Registry**.
I agree to permit my child's record to be shared through the Los Angeles Regional Immunization Registry computer system.

_____ _____
Signature Date

He leído, y entiendo la información para padres/apoderados del **Registro de Vacunas Regional de Los Angeles**. Estoy de acuerdo y doy mi consentimiento para que la información de vacunas de mi hijo/a sea compartida a través del sistema computarizado del registro de Vacunas Regional de Los Angeles.

_____ _____
Firma Fecha

IMPORTANT: READ THI S BEFORE SIGNING BEL OW

I have been given and have read, or have had explained to me, the information contained in the "Vaccine Information Material(s)" (Vaccine Information Statements or "Important Information Statement(s)") about the disease(s) and vaccine(s) indicated below. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) and request that the vaccine(s) indicated below be given to me or to the person named below for whom I am authorized to make this request.

Me han dado una copia y he leido, o me han explicado la información contenida en el "Folleto de Información Sobre las Vacunas" sobre las enfermedades y vacunas indicadas abajo. He tenido oportunidad de hacer preguntas, las que me han sido contestadas a mi completa satisfación. Creo que entiendo los beneficios y los riesgos de las vacunas y pido que estas vacunas me sean aplicadas a mi o la persona cuyo nombre aparece abajo por quien estoy autorizado para hacer esta solicitud.

Please sign next to the checked boxes indicating that you have read the Vaccine Information Materials and consent to your child receiving the checked immunizations.

DTP ☐ _____ SIGNATURE _____ DATE

HIB ☐ _____ SIGNATURE _____ DATE

OPV/IPV ☐ _____ SIGNATURE _____ DATE

DTP/HIB ☐ _____ SIGNATURE _____ DATE

MMR ☐ _____ SIGNATURE _____ DATE

HEP B ☐ _____ SIGNATURE _____ DATE

Immunization Record Card
County of Los Angeles Department of Health Services
Public Health Programs

H-519A (Supplemental Form-Rev. 09/94)

Patient's Name, Record Number and Date of Birth

IMPORTANT: READ THI S BEFORE SIGNING BEL OW

I have been given and have read, or have had explained to me, the information contained in the "Vaccine Information Material(s)" (Vaccine Information Statements or "Important Information Statement(s)") about the disease(s) and vaccine(s) indicated below. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) and request that the vaccine(s) indicated below be given to me or to the person named below for whom I am authorized to make this request.

Me han dado una copia y he leido, o me han explicado la información contenida en el "Folleto de Información Sobre las Vacunas" sobre las enfermedades y vacunas indicadas abajo. He tenido oportunidad de hacer preguntas, las que me han sido contestadas a mi completa satisfación. Creo que entiendo los beneficios y los riesgos de las vacunas y pido que estas vacunas me sean aplicadas a mi o la persona cuyo nombre aparece abajo por quien estoy autorizado para hacer esta solicitud.

Please sign next to the checked boxes indicating that you have read the Vaccine Information Materials and consent to your child receiving the checked immunizations.

DTP ☐ _____ SIGNATURE _____ DATE

HIB ☐ _____ SIGNATURE _____ DATE

OPV/IPV ☐ _____ SIGNATURE _____ DATE

DTP/HIB ☐ _____ SIGNATURE _____ DATE

MMR ☐ _____ SIGNATURE _____ DATE

HEP B ☐ _____ SIGNATURE _____ DATE

Immunization Record Card
County of Los Angeles Department of Health Services
Public Health Programs

H-519A (Supplemental Form-Rev. 09/94)

Patient's Name, Record Number and Date of Birth

SCHOOL-LINKED HEALTH CENTER **SCHOOL** _____

PARENT/LEGAL GUARDIAN/ADULT CAREGIVER CONSENT FORM

Name of student: _____ School: _____ Grade: _____

Address: _____

_____ Home Phone: _____

Birthdate: _____ Social Security No.: _____
(if available)

Allergies: _____

Parent/Legal Guardian/Adult Caregiver Emergency or Work Phone Number: _____

I/We have read and understand the services offered at the School-Linked Health Center as described below. I/We understand further that the services authorized by my/our signature on this form are simple, common, or routine health care services, and may include:

- Diagnosis and treatment for minor and acute illnesses
- First aid for minor injuries
- Physical examinations (general, sports, pre-employment)
- Assistance with chronic (ongoing) illnesses, such as asthma, diabetes, and epilepsy
- Treatment of acne and other skin problems
- Immunizations
- Dental, vision, and hearing screening
- Laboratory services
- Prescriptive and over-the-counter items
- Diet and weight control programs
- Alcohol and other drug abuse counseling and referral
- Psychological Services
- Referrals for health care services which cannot be provided at school-linked health centers
- GU exam

I have listed below those services which I do **NOT** want this student to receive at the School-Linked Center:

_____

_____

I/We understand that this consent covers only those services provided at this clinic, and does not authorize services rendered at any other private or public facility.

I/We hereby authorize a physician and other professional clinic staff to provide necessary and/or advisable treatment for my son/daughter. This student has my/our permission to receive all services offered at the School-Linked Health Center, **EXCEPT** those which I have specifically excluded above.

Student's Signature: _____ Date: _____

_____ Relationship: _____
(Print name of Parent/Legal Guardian/Adult Caregiver)

Signature of Parent/Legal Guardian/Adult Caregiver: _____ Date: _____

_____ Telephone: _____
Address of Parent/Legal Guardian/Adult Caregiver

Witness Signature: _____ Date: _____

Witness Address: _____ Telephone: _____

CENTRO DE SALUD ESCOLAR **ESCUELA** _____

FORMA DE CONSENTIMIENTO DEL PADRE O MADRE/GUARDIÁN LEGAL/ADULTO ENCARGADO DEL MENOR

Nombre del estudiante: _____ Escuela: _____ Grado: _____

Dirección: _____

_____ Teléfono del hogar: _____

Fecha de Nacimiento: _____ Número de Seguro Social: _____
(si disponible)

Alergias: _____

Número de teléfono de emergencia o de trabajo del Padre o Madre/Guardian Legal/Adulto encargado del menor: _____

Yo/Nosotros he/hemos leido y entiendo los servicios ofrecidos por el Centro de Salud Escolar tal como estan detallados abajo. Yo/Nosotros entendemos que los servicios autorizados por mi/nuestra firma en está forma son para servicios simple, común o de rutina de cuidado de salud, y pueden incluir:

- Diagnostico y tratamiento de enfermedades menores y agudas
- Primeros auxilios para heridas menores
- Exámenes físicos (general, deportes, antes de empleo)
- Asistencia con enfermedades crónicas, como el asma, diabetis, y epilepsia
- Tratamiento del acne y otros problemas de la piel
- Inmunizaciones
- Exámenes de detección dental, vision y audición (oídos)
- Servicios de laboratorio
- Artículos con receta médica o que no requieren receta
- Programas para el control de peso y dieta
- Consejo y referencia sobre el alcohol y abuso de otras drogas
- Servicios psicológicos
- Referencias para servicios de cuidado de salud los cuales no pueden ser proveídos en el Centro de Salud Escolar
- Exámen GU

Abajo, he indicado los siguientes servicios que **NO** quiero que el estudiante reciba en el Centro de Salud Escolar:

_____

_____

Yo/Nosotros entiendo/entendemos que este consentimiento cubre solo los servicios proveídos en está clínica, y no autoriza ofrecidos en otra facilidad privada o pública.

Yo/Nosotros autorizo/autorizamos al medico y cualquier otro profesional de la clínica para proveer el tratamiento necesario y/o aconsejable a mi hijo/hija. Este estudiante tiene mi/nuestro permiso para recibir todos los servicios en el Centro de Salud Escolar, con **EXCEPCIÓN** de los servicios que he indicado anteriormente.

Firma del Estudiante: _____ Fecha: _____

_____ Relación: _____
(Escriba el Nombre del Padre o Madre/Guardián legal/Adulto encargado del menor)

Firma del Padre o Madre/Guardián legal/Adulto encargado del menor: _____ Fecha: _____

_____ Teléfono: _____
Dirección del Padre o Madre/Guardián legal/Adulto encargado del menor

Firma del Testigo: _____ Fecha: _____

Dirección del Testigo: _____ Teléfono: _____

PASADENA UNIFIED SCHOOL DISTRICT
HEALTH HISTORY and IMMUNIZATION RECORD for K-12

To Parent/Guardian:

Please complete the HEALTH HISTORY and IMMUNIZATION RECORD at time of Registration. This information is required (by California Law) before enrollment.

Pupil _____ _____ _____
first middle Last name
Birthdate Birthplace

Address _____ Phone
Number Street City ZIP

School _____ Grade _____ Male _____ Female _____

FAMILY INFORMATION

Father _____ lives in home Yes ____ No ____ _____
Last name first middle Occupation

Mother _____ lives in home Yes ____ No ____ _____
Last name first middle Occupation

Brothers (ages) _____ ____ ____ ____ Sisters (ages) _____ ____ ____ ____ Others _____

IMMUNIZATION RECORD			Date Given
DTP	Diphtheria Tetanus Pertussis *after age 4 for Kdg* *after age 6 for 1-12*	1st 2nd 3rd 4th Booster	
Td	Tetanus Diphtheria *after age 6*	1st 2nd 3rd Booster	
IPV/OPV	Polio *after age 4 for Kdg* *after age 6 for 1-12*	1st 2nd 3rd Booster	
MMR	(Measles, Mumps, Rubella) *2 doses for Kindergarten and 7th grade entry* *1 dose grades 1-6, 8-12 given after first birthday*	1st 2nd	
Hepatitis B	*Kindergarten and 7th grade entry*	1st 2nd 3rd	
Varicella	*1 dose for Kindergarten entry*	1st	
Tb	PPD Mantoux Test *registration for Kindergarten entry*		

MEDICAL HISTORY	No	Yes
Asthma	☐	☐
On Asthma Medication?	☐	☐
Chickenpox	☐	☐
Mononucleosis	☐	☐
Pneumonia	☐	☐
Convulsions	☐	☐
Heart Disease	☐	☐
Rheumatic Fever	☐	☐
Meningitis	☐	☐
Anemia	☐	☐
Ear Infection	☐	☐
Frequent Colds	☐	☐
Frequent Sore Throats	☐	☐
Diabetes	☐	☐
Kidney Disease	☐	☐
Allergy	☐	☐
Sickle Cell Disease	☐	☐
Other Illnesses*	☐	☐
Hospitalization*	☐	☐
Surgeries/Fractures*	☐	☐
Wears Glasses	☐	☐
Speech Defect	☐	☐
Hearing Difficulty	☐	☐

*Explain _____

Is your child taking prescription medicine for a chronic condition?
Yes _____

Does anyone in the family have:
Asthma _____ Seizures ____
Heart Disease ____ Diabetes ____
Sickle Cell Disease _____

Please bring an official record of your child's immunizations when you register.

Do you have Health Insurance? Yes ____ No _____
Do you have Medi-Cal? Yes ____ No _____

Parent/Guardian Signature _____

Date _____

DISTRITO ESCOLAR UNIFICADO DE PASADENA
HISTORIA DE SALUD y DE VACUNACION para los grades K - 12

Padre/Tutor:

Por favor complete la HISTORIA DE SALUD y REGISTRO DE VACUNACIÓN al tiempo de matricular a su niño/a. Esta información es requerida (por la Ley de California) antes de matricularse.

Alumno/a _____ _____ _____
Apellido Nombre Segundo Nombre Fecha de Nacimiento Lugar de Nacimiento

Domicilio _____ _____
Número Calle Ciudad Zona Postal Teléfono

Escuela: _____ Grado_____ Masculino_____ Femenino_____

INFORMACIÓN DE LA FAMILIA

Padre _____ ¿Vive en casa? Sí___ No____ _____
Apellido Nombre Segundo Nombre Ocupación

Madre _____ ¿Vive en casa? Sí___ No____ _____
Apellido Nombre Segundo Nombre Ocupación

Hermanos (edades) _____ ____ ____ Hermanas (edades) _ __ __ __ __ Otros_____

REGISTRO DE VACUNACIÓN			Fecha
DTP	Difteria	1a	
	Tétano	2a	
	Tos Ferina	3a	
Para Kinder, después de 4 años de edad		4a	
Para 1º-12º., después de 6 años de edad		Refuerzo	
Td	Tétano	1a	
	Difteria	2a	
		3a	
	después de 6 años de edad	Refuerzo	
IPV/OPV	Polio	1a	
		2a	
Para Kinder, después de 4 años de edad		3a	
Para 1º-12º., después de 6 años de edad		Refuerzo	
MMR	(Sarampión, Paperas,	1a	
	Sarampión Alemán)	2a	
	2 dósis para Kinder y 7º grado		
	1 dósis para 1º-6º, 8º-12º grados		
	después del primer cumpleaños		
Hepatitis B	*para Kinder y 7º grado*	1a	
		2a	
		3a	
Varicella	*1 dósis para Kinder*	1a	
Tb	PPD Prueba Mantoux		
	de matricularse para Kinder		

Por favor presente un registro oficial de las vacunas de su niño cuando lo matricule.

¿Tiene seguro médico? Sí_____No_____
¿Tiene Medi-Cal? Sí_____No_____

Firma del Padre/Tutor: _____

Fecha _____

HISTORIA MÉDICA	No	Sí
Asma -	☐	☐
¿Toma medicina para asma?	☐	☐
Viruelas	☐	☐
Mononucleosis	☐	☐
Pulmonía	☐	☐
Convulsiones	☐	☐
Enfermedad del Corazón	☐	☐
Fiebre Reumática	☐	☐
Meningitis	☐	☐
Anemia	☐	☐
Infección del Oído	☐	☐
Resfriados Frecuentes	☐	☐
Dolor de Garganta Frec.	☐	☐
Diabetes	☐	☐
Enfermedad de los Riñones	☐	☐
Alergia	☐	☐
Célula Falsiforme	☐	☐
Otras Enfermedades*	☐	☐
Hospitalización*	☐	☐
Operaciones/Fracturas*	☐	☐
Usa Lentes Defecto	☐	☐
del Habla	☐	☐
Sordera	☐	☐

*Explique _____

_____

_____

¿Está su niño tomando medicina prescrita por el médico para una enfermedad crónica?
Sí_____ No___ Si la respuesta es afirmativa, diga cual.

_____

_____

Tiene alguien en la familia:
Asma_____ Convulsiones
Célula Falsiforme_____ Diabetes
Enfermedad del Corazón_____

SPORTS PARTICIPATION HEALTH RECORD

This evaluation is only to determine readiness for sports participation. It should not be used as a substitute for regular health maintenance examinations.

NAME_____ AGE_____(YRS) GRADE_____DATE_____

ADDRESS_____ PHONE _____

SPORTS _____

The Health History (Part A) and Physical Examination (Part C) sections must both be completed, at least every 24 months before sports participation. The Interim Health History section (Part B) needs to be completed at least annually.

PART A – HEALTH HISTORY:
To be completed by athlete and parent

	YES	NO
1. Have you every had an illness that:		
a. required you to stay in the hospital?	____	____
b. lasted longer than a week?	____	____
c. caused you to miss 3 days of practice or a competition?	____	____
d. is related to allergies? (i.e. hay fever, hives, asthma, insect stings)	____	____
e. required an operation?	____	____
f. is chronic? (i.e. asthma, diabetes, etc)I	____	____
2. Have you ever had an injury that:		
a. required you to go to an emergency room or see a doctor?	____	____
b. required you to stay in the hospital?	____	____
c. required x-rays?	____	____
d. caused you to miss 3 days of practice or a competition?	____	____
e. required an operation?	____	____
3. Do you take any medication or pills?	____	____
4. Have any members of your family under age 50 had a heart attack, heart problem, or died unexpectedly?	____	____
5. Have you ever:		
a. been dizzy or passed out during or after exercise?	____	____
b. been unconscious or had a concussion?	____	____
6. Are you unable to run ½ mile (2 times around the track) without stopping?	____	____
7. Do you:		
a. wear glasses or contacts?	____	____
b. wear dental bridges, plates, or braces?	____	____
8. Have you ever had a heart murmur, high blood pressure, or a heart abnormality?	____	____
9. Do you have any allergies to any medicine?	____	____
10. Are you missing a kidney?	____	____
11. When was your last tetanus booster?	____	____

12. For Women

a. At what age did you experience your first menstrual period? _____

b. In the last year, what is the longest time you have gone between periods? _____

EXPLAIN ANY "YES" ANSWERS _____

_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are correct.

Date _____

Signature of athlete _____

Signature of parent _____

PART B – INTERIM HEALTH HISTORY:
This form should be used during the interval between pre-participation evaluations. Positive responses should prompt a medical evaluation.

1. Over the next 12 months, I wish to participate in the following sports:

a._____
b._____
c._____
d._____

2. Have you missed more than 3 consecutive days of participation in usual activities because of an injury this part year?

Yes_____No _____
If yes, please indicate:
a. Site of injury _____
b. Type of injury _____

3. Have you missed more than 3 consecutive days of participation in usual activities because of an illness, or have you had a medical illness diagnosed that has not been resolved in this past year?

Yes_____No _____
If yes, please indicate:
a. Type of illness ___

4. Have you had a seizure, concussion or been unconscious for any reason in the last year?

Yes_____No _____

5. Have you had any surgery or been hospitalized in this past year?

Yes_____No _____
If yes, please indicate:
a. Reason for hospitalization _____
b. Type of surgery _____

6. List all medications you are presently taking and what condition the medication is for.

a. _____
b. _____
c. _____

7. Are you worried about any problem or condition at this time?

Yes_____No _____
If yes, please explain: _____

_____

_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are correct.

Date _____

Signature of athlete _____

Signature of parent _____

RÉCORD DE SALUD PARA PARTICIPAR EN DEPORTES

Esta evaluación es sólo para determinar la aptitud para la participación en deportes. No debe usarse para substituir el mantenimiento de exámenes regulares de salud.

NOMBRE_____ EDAD_____ (AÑOS) GRADO:_____ FECHA_____

DOMICILIO_____ TELÉFONO:_____

DEPORTES: _____

Por favor complete ambas secciones, la de Historia de Salud (Parte A) y Examen Físico (Parte C), cuando menos cada 24 meses, antes de la participación en los deportes. La sección interina de Historia de Salud (Parte B) necesita completarse cuando menos cada año.

PARTE A – HISTORIA DE SALUD:

Para que la completen el atleta y el padre

		SI	NO
1.	¿Ha tenido alguna enfermedad que:		
	a. requirió hospitalización?	_____	_____
	b. le duró más de una semana?	_____	_____
	c. le causó que perdiera 3 días de práctica o una competencia?	_____	_____
	d. está relacionada con alergias? (ej. fiebre del heno, urticaria, asma, piquetes de insectos)	_____	_____
	e. requirió operación?	_____	_____
	f. es crónica? (ej. asma, diabetes, etc.)	_____	_____
2.	¿Ha tenido alguna vez una lastimadura que:		
	a. requirió que fuera a la emergencia o a ver a un médico?	_____	_____
	b. requirió que se quedara en el hospital?	_____	_____
	c. requirió Rayos X?	_____	_____
	d. le causó que perdiera 3 días de práctica o una competencia?	_____	_____
	e. requirió una operación?	_____	_____
3.	¿Toma alguna medicina o pastillas?	_____	_____
4.	¿ Ha sufrido alguien de su familia, menor de 50 años, un ataque cardiaco, problema del corazón, o ha muerto inesperadamente?	_____	_____
5.	¿Alguna vez:		
	a. ha tenido mareos, o se ha desmayado durante o después de hacer ejercicio?	_____	_____
	b. ha estado inconsciente o ha tenido una conmoción cerebral?	_____	_____
6,	¿No puede correr ½ milla (dos veces alrededor de la pista) sin detenerse?	_____	_____
7.	¿Usted:		
	a. usa lentes o lentes de contacto?	_____	_____
	b. usa puentes dentales, placas, o frenos?	_____	_____
8.	¿Ha tenido alguna vez un murmullo en el corazón, alta presión de sangre, o una anormalidad del corazón?	_____	_____
9.	¿Es alérgico a alguna medicina?	_____	_____
10	¿Le falta un riñón?	_____	_____
11.	¿Cuándo fue su último refuerzo contra el tétanos?_____		
12.	**Para Mujeres**		
	a. ¿A qué edad tuvo su primera menstruación? _____		
	b. En el último año, ¿Cuál es el tiempo más largo que ha tenido entre períodos? _____		

SI CONTESTÓ "SI", EXPLIQUE: _____

_____

Por medio de la presente y en la medida de mi capacidad, mis respuestas a las preguntas anteriores son correctas.

Fecha: _____

Firma del Atleta: _____

Firma del Padre/Tutor:_____

PARTE B – HISTORIA INTERINA DE SALUD:

Esta forma debe usarse durante los intervalos entre evaluaciones de participación. Respuestas positivas deben sugerir una evaluación médica.

1. Durante los próximos 12 meses, deseo participar en los deportes siguientes:
   a. _____
   b. _____
   c. _____
   d. _____
2. ¿Ha dejado de participar más de 3 días consecutivos en las actividades regulares debido a una lastimadura del año pasado?
   Si_____ No _____
   Si la respuesta es positiva, por favor indique:
   a. Lugar de la lastimadura _____
   b. Clase de lastimadura _____
3. ¿Ha dejado de asistir más de 5 días consecutivos para participar en actividades regulares debido a enfermedad, o ha sido diagnosticada una enfermedad médica que no se resolvió el año pasado?
   Si_____ No _____
   Si la respuesta es positiva (si) , por favor indique:
   a. Clase de enfermedad_____
4. Tuvo mareos, conmoción cerebral, o se desmayó por cualquier motivo durante el año pasado?
   Si_____ No _____
5. ¿Ha tenido alguna operación de cirugía o fue hospitalizado durante el año pasado?
   Si_____ No _____
   Si la respuesta es positiva, por favor indique:
   a. Motivo para la hospitalización: _____
   b. Clase de cirugía: _____
6. Anote todas las medicinas que está tomando ahora y para qué son:
   a. _____
   b. _____
   c. _____
7. ¿Está preocupado ahora acerca de algún problema o condición médica?
   Si_____ No _____
   Si la respuesta es positiva, por favor explique: ____
   _____
   _____

Por medio de la presente y en la medida de mi capacidad, mis respuestas a las preguntas anteriores son correctas.

Fecha: _____

Firma del Atleta**:** _____

Firma del Padre/Tutor:_____

2 to 20 years: Boys
Body mass index-for-age percentiles (Front)

available at:

http://www.cdc.gov/growthcharts/data/set1clinical/cj41l023.pdf

2 to 20 years: Boys
Stature-for-age and Weight-for-age percentiles

available at:

http://www.cdc.gov/growthcharts/data/set1clinical/cj41l021.pdf

2 to 20 years: Girls
Body mass index-for-age percentiles (Front)

available at:

http://www.cdc.gov/nchs/data/nhanes/growthcharts/set2clinical/cj41l074.pdf

2 to 20 years: Girls
Stature-for-age and Weight-for-age percentiles (Back)

available at:

http://www.cdc.gov/growthcharts/data/set1clinical/cj41l022.pdf

Other versions (including color, other languages, and Birth-36 mos.) available at:

http://www.cdc.gov/growthcharts/clinical_charts.htm

PASADENA UNIFIED SCHOOL DISTRICT
Nurse Practitioner Physical Evaluation

Under 1 Month

Name:_____ **DOB:**_____ **Actual Age:**_____ **Today's Date:**_____

Height: Weight: H C :	**If ill: Temp: Pulse: Resp:**
Allergies:	**Growth Chart Discussed with Parent:**
Exposure to infectious diseases incl. TB:	**WIC Status:**
BIRTH HISTORY	**INTERVAL HISTORY**
Pregnancy Complications:	**Feedings:**
Birth weight: Lb. Oz/ Kg.	**Stools:**
Perinatal Complications:	**Cord:**
Family Hx. Of childhood hearing Impairment:	**Exposure to tobacco smoke:**
Circumcision:	**Infant sleeping position:**

YES	NO	GROWTH DEVELOPMENT	YES	NO	
		Equal movements			**Regards face**
		Lifts head when prone			**Responds to sound**

Immunization / mini screenings ( ) Nutritional Assessment
( ) Obtain new born records if necessary

ANTICIPATORY GUIDANCE

- **( ) Diet:** Breast vs. Formula feeding, no other PO intake, no bottle recumbent, feeding position, colic.
- **( ) Behavior:** Feeding, sleeping, crying, hiccups, stools, sneezing
- **( ) Accident prevention:** Falls, smoke detector, burns from hot liquids
- **( ) Guidance:** Spoiling, reaction to siblings, diaper rash, circ. care, suctioning, protection from infection, smoking at home, Stimulating with hanging objects & bright colors, thermometer use , call MD for fever over 100.5, pacifier.
- **( ) Safety Precautions:** Infant car seat, water safety, falls, nursery equipment
- **( ) Thermometer use**
- **( ) Umbilical care**
- **( ) Infant care** (bathing, skin, clothing)

NURSE SIGNATURE:_____

CC_____

	YES	NO	PHYSICAL EXAMINATION		YES	NO	
General Appearance			Well nourished & developed	**Heart**			No murmurs, regular rhythm
			Abuse / neglect evident	**Lungs**			Breath sounds normal bilaterally
Head			Symmetrical ,AF open_____cm	**Abdomen**			soft, no masses, liver & spleen normal
Eyes			Conjunctivae, sclera, pupils normal	**Genitalia: Male**			Normal appearance, circ. / uncirc.
			Red reflexes present				Testes in scrotum
			Appears to see ( ) no strabismus	**Female**			No lesions, nl. external appearances
Ears			Canals Clear, TMs normal	**Hips**			Symmetrical folds, no clicks
			Appears to hear	**Femoral pulses**			Present & equal
Nose			Passages patent	**Extremities**			No deformities, full ROM
Mouth & Pharynx			Normal color, no lesions	**Skin**			Clear, no significant lesions
Neck			Supple, no masses palpated	**Neurologic**			Alert, moves extremities well

MD Comments: **GUH pamphlet given ( )**

MD Plan:

Next appointment_____ **NP Signature**_____

PASADENA UNIFIED SCHOOL DISTRICT
Nurse Practitioner Physical Evaluation
1-2 Months

Name:_____ **DOB:**_____ **Actual Age:**____ **Today's Date:**_____

Height: **Weight:** **H C :**			**If ill: Temp:** **Pulse:** **Resp:**		
Allergies:			**Growth Chart Discussed with Parent:**		
Exposure to infectious diseases incl. TB:			**WIC Status:**		
INTERVAL HISTORY					
Feedings:			**Accidents:**		
Stools:			**Hearing / vision : problems at home ?**		
Illnesses :			**Sleeping position / pattern:**		
Diaper rash :			**Exposure to tobacco smoke :**		
YES	**NO**	**GROWTH DEVELOPMENT**	**YES**	**NO**	
		Prone lifts head 45 º			**Follows to midline**
		Vocalizes (Cooing)			**Responds to loud sounds**
		Smiles responsively (social)			

Immunization / mini screenings ( ) IPV ( ) DTaP ( ) Hib ( ) Hep B ( ) Prevnar ( ) Nutritional Assessment
( ) Obtain new born records if necessary ( ) Vaccine questionnaire, reactions, risks and follow-up explained

ANTICIPATORY GUIDANCE

- **( ) Diet:** Breast vs. Formula feeding, no milk or honey till 1 yr / old , no bottle recumbent feeding position, colic, WIC referral
- **( ) Behavior:** Crying. Thumb sucking, no discipline yet, sneezing
- **( ) Accident prevention:** Rolling, playpen use, burns from hot liquids
- **( ) Guidance:** Fever, acetaminophen dose, hot water temp. 120 º, ABC's to hear
- **( ) Safety Precautions:** Infant car seat, water safety, falls, nursery equipment
- **( ) Sibling & family relationships**
- **( ) Childcare plan**
- **( ) Emergency care plan**
- **( ) Infant care** (bathing, skin, clothing)
- **( ) Family spacing**
- **( ) Thermometer use, call MD if fever ≥100.5**

NURSE SIGNATURE:_____

CC_____

	YES	NO	PHYSICAL EXAMINATION		YES	NO	
General Appearance			Well nourished & developed	**Heart**			No murmurs, regular rhythm
			Abuse / neglect evident	**Lungs**			Breath sounds normal bilaterally
Head			Symmetrical ,AF open_____cm	**Abdomen**			soft, no masses, liver & spleen normal
Eyes			Conjunctivae, sclera, pupils normal z	**Genitalia: Male**			Normal appearance, circ. / uncirc.
			Red reflexes present				Testes in scrotum
			Appears to see ( ) no strabismus	**Female**			No lesions, nl. external appearances
Ears			Canals Clear, TMs normal	**Hips**			Symmetrical folds, no clicks
			Appears to hear	**Femoral pulses**			Present & equal
Nose			Passages patent	**Extremities**			No deformities, full ROM
Mouth & Pharynx			Normal color, no lesions	**Skin**			Clear, no significant lesions
Neck			Supple, no masses palpated	**Neurologic**			Alert, moves extremities well

MD Comments: **GUH pamphlet given ( )**

MD Plan:

Next appointment_____ **NP Signature**_____

PASADENA UNIFIED SCHOOL DISTRICT
Nurse Practitioner Physical Evaluation

3-4 Months

Name:_____ **DOB:**_____ **Actual Age:**_____ **Today's Date:**_____

Height: **Weight:** **H C :**	**If ill: Temp:** **Pulse:** **Resp:**
Allergies:	**Growth Chart Discussed with Parent:**
Exposure to infectious diseases incl. TB:	**WIC Status:**

INTERVAL HISTORY

Feedings:	**Accidents:**
Stools:	**Hearing : problems at home ?**
Illnesses :	**Vision : problems at home ?**
Diaper rash :	**Exposure to tobacco smoke :**

YES	NO	GROWTH DEVELOPMENT	YES	NO	
		Head steady when held upright			**Orients to voices**
		Vocalizes (Cooing)			**Squeals, laughs**
		Brings hands together			

Immunization / mini screenings **( ) IPV ( ) DTaP ( ) HIB ( ) Hep B ( ) Prevnar**
( ) Vaccine questionnaire, reactions, risks and follow-up explained **( ) Nutritional Assessment**

ANTICIPATORY GUIDANCE

- **( ) Diet:** Breast vs. Formula feeding, no milk or honey till 1 yr / old, no bottle recumbent, feeding position, colic
- **( ) Behavior:** Rolling, reaching for objects, hiccups, sneezing, sleeping
- **( ) Accident prevention:** Rolling, playpen use, burns from hot liquids
- **( ) Guidance:** Fever, acetaminophen dose, hot water temp.120, ABC's to hear, language stimulation, diaper rash, protection from infection, teething
- **( ) Safety Precautions:** Infant car seat, water safety, falls, nursery equipment**,** aspiration risk with small objects
- **( ) Sibling & family relationships**
- **( ) Childcare plan**
- **( ) Emergency care plan**
- **( ) Infant care (bathing, skin, clothing)**
- **( ) Family spacing**
- **( ) Thermometer use, call MD if fever ≥100.5**
- **( ) Minor illness care**

NURSE SIGNATURE:_____

CC_____

	YES	NO	PHYSICAL EXAMINATION		YES	NO	
General Appearance			Well nourished & developed	**Heart**			No murmurs, regular rhythm
			Abuse / neglect evident	**Lungs**			Breath sounds normal bilaterally
Head			Symmetrical ,AF open_____cm	**Abdomen**			soft, no masses, liver & spleen normal
Eyes			Conjunctivae, sclera, pupils normal	**Genitalia: Male**			Normal appearance, circ. / uncirc.
			Red reflexes present				Testes in scrotum
			Appears to see ( ) no strabismus	**Female**			No lesions, nl. external appearances
Ears			Canals Clear, TMs normal	**Hips**			Good abduction
			Appears to hear	**Femoral pulses**			Present & equal
Nose			Passages patent	**Extremities**			No deformities, full ROM
Mouth & Pharynx			Normal color, no lesions	**Skin**			Clear, no significant lesions
Neck			Supple, no masses palpated	**Neurologic**			Alert, moves extremities well

MD Comments: **GUH pamphlet given ( )**

MD Plan:

PASADENA UNIFIED SCHOOL DISTRICT
Nurse Practitioner Physical Evaluation

5-6 Months

Name:_____ **DOB:**_____ **Actual Age:**_____ **Today's Date:**_____

Height: **Weight:** **H C :**	**If ill: Temp:** **Pulse:** **Resp:**
Allergies:	**Growth Chart Discussed with Parent:**
Exposure to infectious diseases incl. TB:	**WIC Status:**
INTERVAL HISTORY	
Diet :	**Accidents:**
Stools:	**Hearing : problems noted at home ?**
Illnesses :	**Vision : problems noted at home ?**
Meds / Vitamins :	**Exposure to tobacco smoke :**

YES	NO	GROWTH DEVELOPMENT	YES	NO	
		Turns to sound			**Rolls over-Supine to prone**
		Reaches for and grasps objects			**Squeals, laughs**
		Babbles repetitive consonants			

Immunization / mini screenings ( ) Nutritional assessment ( ) IPV ( ) DTaP ( ) HIB ( ) Hep B ( ) Prevnar
( ) Vaccine questionnaire, reactions, risks and follow-up explained

ANTICIPATORY GUIDANCE

- **( ) Diet:** Intro solids at 5 mos (rice cereal, vegs / fruit), solids 1 new / week, start with iron-rich, no milk yet, breast-feeding, formula
- **( ) Behavior:** Begins to sit and crawl, discrimination of people
- **( ) Accident prevention:** Rolling, playpen use, burns from hot liquids**,** smoke detector, poisoning risk, drug and toxic chemicals storage, hot water temp, Ipecac poison center phone number, child proofing, safety gates, window guards, pool fence hot liquids and surfaces**,** choking prevention
- **( ) Guidance:** Consistent sleep schedule, teething, blocks, repetitive games, no bottle recumbent
- **( ) Infant vs Toddler car seat**
- **( ) Sibling & family relationships**
- **( ) Childcare plan**
- **( ) Emergency care plan** **( ) Rx for fluoride drops:** Tri-ViFlor / Luride 25 mg./ 50 mg.QD, refill till age 2
- **( ) Thermometer use, call MD if fever ≥100.5**

NURSE SIGNATURE:_____

CC_____

	YES	NO	PHYSICAL EXAMINATION		YES	NO	
General Appearance			Well nourished & developed	**Heart**			No murmurs, regular rhythm
			Abuse / neglect evident	**Lungs**			Breath sounds normal bilaterally
Head			Symmetrical ,AF open_____cm	**Abdomen**			Soft, no masses, liver & spleen normal
Eyes			Conjunctivae, sclera, pupils normal	**Genitalia: Male**			Normal appearance, circ. / uncirc.
			Red reflexes present				Testes in scrotum
			Appears to see ( ) no strabismus	**Female**			No lesions, nl. external appearances
Ears			Canals Clear, TMs normal	**Hips**			Good abduction
			Appears to hear	**Femoral pulses**			Present & equal
Nose			Passages patent	**Extremities**			No deformities, full ROM
Mouth & Pharynx			Normal color, no lesions	**Skin**			Clear, no significant lesions
Neck			Supple, no masses palpated	**Neurologic**			Alert, moves extremities well

MD Comments: **GUH pamphlet given ( )**

MD Plan:

PASADENA UNIFIED SCHOOL DISTRICT
Nurse Practitioner Physical Evaluation

7-9 Months

Name:_____ **DOB:**_____ **Actual Age:**_____ **Today's Date:**_____

Height: **Weight:** **H C :**	**If ill: Temp:** **Pulse:** **Resp:**
Allergies:	**Growth Chart Discussed with Parent:**
Exposure to infectious diseases incl. TB:	**WIC Status:**
INTERVAL HISTORY	
Diet :	**Accidents:**
Stools:	**Hearing :**
Illnesses :	**Vision :**
Meds / Vitamins :	**Exposure to tobacco smoke :**

YES	NO	GROWTH DEVELOPMENT	YES	NO	
		Turns to sound			**Uses paired consonants**
		Brings self to sitting position			**Transfers objets hand to hand**
		Peek-a-boo social games			**Finger feeds**

Immunization /mini screenings ( ) IPV ( ) DTaP ( ) HIB ( ) Hep B ( ) Prevnar ( ) Nutritional assessment **( ) Hgb**
( ) Vaccine questionnaire, reactions, risks and follow-up explained

ANTICIPATORY GUIDANCE

( ) Diet: Mashed table food, finger foods, start cup, introduce egg
( ) Behavior: Sitting, crawling, creeping, trying to pull self up
( ) Accident prevention: No food chunks or hard objects the size of a baby's pinky , smoke detector, poisoning risk, drug and toxic chemicals storage, Ipecac poison center phone number, burns, hot liquids and foods, water / pool safety
( ) Guidance: Decrease in appetite, understands "no" but no discipline, brush teeth, no bottle recumbent

( ) Sibling & family relationships
( ) Child care plan
( ) Childcare plan
( ) Rx for fluoride drops: Tri-ViFlor / Luride 25 mg./ 50 mg.QD, refill till age 2
( ) Toddler car seat >20 lb.
( ) Dental Hygiene
( ) Teething problems

NURSE SIGNATURE:_____

CC_____

	YES	NO	PHYSICAL EXAMINATION		YES	NO	
General Appearance			Well nourished & developed	**Teeth**			Grossly normal
			Abuse / neglect evident	**Heart**			No murmurs, regular rhythm
				Lungs			Breath sounds normal bilaterally
Head			Symmetrical ,AF open_____cm	**Abdomen**			Soft, no masses, liver & spleen normal
Eyes			Conjunctivae, sclera, pupils normal	**Genitalia: Male**			Normal appearance, circ. / uncirc.
			Red reflexes present				Testes in scrotum
			Appears to see ( ) no strabismus	**Female**			No lesions, nl. external appearances
Ears			Canals Clear, TMs normal	**Hips**			Good abduction
			Appears to hear	**Femoral pulses**			Present & equal
Nose			Passages patent	**Extremities**			No deformities, full ROM
Mouth & Pharynx			Normal color, no lesions	**Skin**			Clear, no significant lesions
Neck			Supple, no masses palpated	**Neurologic**			Alert, moves extremities well

MD Comments: **GUH pamphlet given ( )**

MD Plan:

Next appointment_____ **NP Signature**_____

PASADENA UNIFIED SCHOOL DISTRICT
Nurse Practitioner Physical Evaluation

10-12 Months

Name:_____ **DOB:**_____ **Actual Age:**_____ **Today's Date:**_____

Height: **Weight:** **H C :**	**If ill: Temp:** **Pulse:** **Resp:**
Allergies:	**Growth Chart Discussed with Parent:**
Exposure to infectious diseases incl. TB:	**WIC Status:**
INTERVAL HISTORY	
Diet :	**Accidents:**
Stools:	**Hearing :**
Illnesses :	**Vision :**
Meds / Vitamins :	**Exposure to tobacco smoke :**

YES	NO	GROWTH DEVELOPMENT	YES	NO	
		Dada, Mama, specific			**Neat pincer grasp**
		1 - 3 other meaningful sounds			**Plays pat-a-cake Social games**
		Walks with assistance			

Immunization /mini screenings ( ) IPV ( ) DTaP ( ) HIB ( ) Hep B ( ) Prevnar ( ) MMR ( ) Varicella (> 12 mo.) **( ) Lead blood test**

( ) Nutritional assessment ( ) Vaccine questionnaire, reactions, risks and follow-up explained ( ) Hx. Of Chicken Pox Disease

ANTICIPATORY GUIDANCE

- **( ) Diet:** Intro meats and proteins, mashed table food, finger foods, start feeder cup, milk, no junk food, weaning, normal decreased appetite
- **( ) Behavior:** Minor discipline, pulls to standing
- **( ) Accident prevention:** No hard objects the size of a baby's pinky, smoke detector, drug and chemicals storage Ipecac poison center phone number, child proofing, electrical outlet covers, safety guards, pool fence, hot liquids and surfaces**,** hot water temp, drowning, street safety, falls, gun in home, Walker, stairs, windows
- **( ) Guidance:** Allow feed self, looking in mirror, playing with cloth book, and expecting growth and appetite to decrease
- **( ) Safety precautions:** Infant car seat, water safety, falls, nursery equipment
- **( ) Childcare plan**
- **( ) Toddler car seat**

NURSE SIGNATURE:_____

CC_____

	YES	NO	PHYSICAL EXAMINATION		YES	NO	
General Appearance			Well nourished & developed	**Teeth**			Grossly normal
			Abuse / neglect evident	**Heart**			No murmurs, regular rhythm
				Lungs			Breath sounds normal bilaterally
Head			Symmetrical ,AF open_____cm	**Abdomen**			Soft, no masses, liver & spleen normal
Eyes			Conjunctivae, sclera, pupils normal	**Genitalia: Male**			Normal appearance, circ. / uncirc.
			Red reflexes present				Testes in scrotum
			Appears to see ( ) no strabismus	**Female**			No lesions, nl. external appearances
Ears			Canals Clear, TMs normal	**Hips**			Good abduction
			Appears to hear	**Femoral pulses**			Present & equal
Nose			Passages patent	**Extremities**			No deformities, full ROM
Mouth & Pharynx			Normal color, no lesions	**Skin**			Clear, no significant lesions
Neck			Supple, no masses palpated	**Neurologic**			Alert, moves extremities well

MD Comments: **GUH pamphlet given ( )**

MD Plan:

Next appointment_____ **NP Signature**_____

PASADENA UNIFIED SCHOOL DISTRICT
Nurse Practitioner Physical Evaluation

13-15 Months

Name:_____ **DOB:**_____ **Actual Age:**_____ **Today's Date:**_____

Height: **Weight:** **H C :**	**If ill: Temp:** **Pulse:** **Resp:**
Allergies:	**Growth Chart Discussed with Parent:**
Exposure to infectious diseases incl. TB:	**WIC Status:**
INTERVAL HISTORY	
Diet :	**Accidents:**
Stools:	**Hearing :**
Illnesses :	**Vision :**
Meds / Vitamins :	**Exposure to tobacco smoke :**

YES	NO	GROWTH DEVELOPMENT	YES	NO	
		Walks alone well			**3 - 6 word vocabulary**
		Stoops and recovers			**Indicates wants without cry**
		Drinks from a cup			**Neat pincer grasp**

Immunization /mini screenings ( ) Any catch up vaccines _____ ( ) Lead blood test (if not previously done)
( )Nutritional assessment ( )Vaccine questionnaire, reactions, risks and follow-up explained ( )Hx. Of Chicken Pox Disease **( )Hgb**

ANTICIPATORY GUIDANCE

( ) Diet: Table foods, milk, junk food, using cup / bottle, encourage solids

( ) Behavior: Feeding self, simple games

( ) Accident prevention: No hard objects the size of a baby's pinky, smoke detector, drug and chemicals storage Ipecac poison center phone number, child proofing, electrical outlet covers, safety gates, pool fence, hot liquids and surfaces**,** hot water temp, drowning, street safety, falls, gun in home, stairs, window guards**,** home first aid kit, matches, cabinets and latches

( ) Guidance: Explain temper tantrums, family play, masturbation, not ready for toilet training, shoes, toothbrush, treatment of minor cuts and bruises

( ) Rx for fluoride drops: Tri-ViFlor / Luride 25 mg./ 50 mg.QD, refill till age 2

( ) Childcare plan

( ) Toddler car seat

NURSE SIGNATURE:_____

CC_____

	YES	NO	PHYSICAL EXAMINATION		YES	NO	
General Appearance			Well nourished & developed	**Teeth**			Grossly normal
				Heart			No murmurs, regular rhythm
			Abuse / neglect evident	**Lungs**			Breath sounds normal bilaterally
Head			Symmetrical ,AF open____cm	**Abdomen**			Soft, no masses, liver & spleen normal
Eyes			Conjunctivae, sclera, pupils normal	**Genitalia: Male**			Normal appearance, circ. / uncirc.
			Red reflexes present				Testes in scrotum
			Appears to see ( ) no strabismus	**Female**			No lesions, nl. external appearances
Ears			Canals Clear, TMs normal	**Hips**			Good abduction
			Appears to hear	**Femoral pulses**			Present & equal
Nose			Passages patent	**Extremities**			No deformities, full ROM
Mouth & Pharynx			Normal color, no lesions	**Skin**			Clear, no significant lesions
Neck			Supple, no masses palpated	**Neurologic**			Alert, moves extremities well

MD Comments: **GUH pamphlet given ( )**

MD Plan:

Next appointment_____ **NP Signature**_____

PASADENA UNIFIED SCHOOL DISTRICT
Nurse Practitioner Physical Evaluation

16-23 Months

Name:_____ **DOB:**_____ **Actual Age:**_____ **Today's Date:**_____

Height: **Weight:** **H C :**	**If ill: Temp:** **Pulse:** **Resp:**
Allergies:	**Growth Chart Discussed with Parent:**
Exposure to infectious diseases incl. TB:	**WIC Status:**
INTERVAL HISTORY	
Diet :	**Accidents:**
Stools:	**Hearing :**
Illnesses :	**Sleep pattern :**
Meds / Vitamins :	**Exposure to tobacco smoke :**

YES	NO	GROWTH DEVELOPMENT	YES	NO	
		Walks alone fast			**Feeds self with spoon**
		Scribbles			**4-10 word vocabulary**

Immunization /mini screenings ( )Any catch up vaccines _____ ( ) Lead blood test (if not previously done)
( )Nutritional assessment ( )Vaccine questionnaire reactions, risks and follow-up explained

ANTICIPATORY GUIDANCE

- **( ) Diet:** Table foods, milk, junk food, using cup / bottle, encourage solids
- **( ) Behavior:** Feeding self, simple games
- **( ) Accident prevention:** No hard objects the size of a baby's pinky, smoke detector, drug and chemicals storage Ipecac poison center phone number, child proofing, electrical outlet covers, safety gates, pool fence, hot liquids and surfaces**,** hot water temp, drowning, street safety, falls, gun in home, stairs, window guards**,** home first aid kit, matches, cabinets and latches
- **( ) Guidance:** Explain temper tantrums, family play, masturbation, not ready for toilet training, shoes, toothbrush, treatment of minor cuts and bruises
- **( ) Rx for fluoride drops:** Tri-ViFlor / Luride 25 mg./ 50 mg.QD, refill till age 2
- **( ) Childcare plan**
- **( ) Toddler car seat**

NURSE SIGNATURE:_____

CC_____

	YES	NO	PHYSICAL EXAMINATION		YES	NO	
General Appearance			Well nourished & developed	**Teeth**			Grossly normal
				Heart			No murmurs, regular rhythm
			Abuse / neglect evident	**Lungs**			Breath sounds normal bilaterally
Head			Symmetrical ,AF open_____cm	**Abdomen**			Soft, no masses, liver & spleen normal
Eyes			Conjunctivae, sclera, pupils normal	**Genitalia: Male**			Normal appearance, circ. / uncirc.
			Red reflexes present				Testes in scrotum
			Appears to see ( ) no strabismus	**Female**			No lesions, nl. external appearances
Ears			Canals Clear, TMs normal	**Hips**			Good abduction
			Appears to hear	**Femoral pulses**			Present & equal
Nose			Passages patent	**Extremities**			No deformities, full ROM
Mouth & Pharynx			Normal color, no lesions	**Skin**			Clear, no significant lesions
Neck			Supple, no masses palpated	**Neurologic**			Alert, moves extremities well

MD Comments: **UH pamphlet given ( )**

MD Plan:

Next appointment_____ **NP Signature**_____

PASADENA UNIFIED SCHOOL DISTRICT
Nurse Practitioner Physical Evaluation

2 YEARS

Name:_____ **DOB:**_____ **Actual Age:**_____ **Today's Date:**_____

Height: Weight: BMI:	**If ill: Temp: Pulse: Resp:**
Allergies:	**Growth Chart Discussed with Parent:**
Exposure to infectious diseases:	**WIC Status:**
INTERVAL HISTORY	
Diet :	**Accidents:**
Stools:	**Hearing :**
Illnesses :	**Sleep pattern :**
Meds / Vitamins :	**Exposure to tobacco smoke :**

YES	NO	GROWTH DEVELOPMENT	YES	NO	
		Runs with ease			**Some word phrases with I, Me, You**
		Puts on and removes some clothing			**Imitates housework**
		Throws ball overhead			**Follows simple directions**

Immunization /mini screenings ( )Any catch up vaccines _____ **( ) Hep A ( ) Lead blood test** ( )Nutritional assessment

( ) Hgb ( )Vaccine questionnaire, reactions, risks and follow-up explained ( )Hx of chicken Pox Disease ( )PPD only for identified risk

ANTICIPATORY GUIDANCE

- **( ) Diet:** Regular meals with snacks, iron-rich foods, sodium, caloric balance, switch to low-fat milk
- **( ) Behavior:** Runs but falls down easily, loves rough play
- **( ) Accident prevention:** Street dangers, knifes, falls, smoke detector, matches, drug and chemicals storage, Ipecac poison center phone number, pool fence, hot water temp, drowning,, gun in home, window guards**,** home first aid kit, matches, bike helmet, play equipment
- **( ) Guidance:** Accept negativism, monitor TV programs, start toilet training, parallel peer play, brush teeth, dentist Q 1-2 years, protect skin from UV light
- **( ) Rx for fluoride drops:** Tri-ViFlor / Luride 25 mg./ 50 mg.QD, refill till age 2
- **( ) Safety precautions:** Infant car seat, water safety, falls, nursery equipment
- **( ) Childcare plan**
- **( ) Toddler car seat**
- **( ) Sibling and family relationships**
- **( ) Emergency care plan**

NURSE SIGNATURE:_____

CC_____

	YES	NO	PHYSICAL EXAMINATION		YES	NO	
General Appearance			Well nourished & developed	**Teeth**			Grossly normal
			Abuse / neglect evident	**Heart**			No murmurs, regular rhythm
Eyes			Conjunctivae, sclera, pupils normal	**Lungs**			Breath sounds normal bilaterally
			Red reflexes present	**Abdomen**			Soft, no masses, liver & spleen normal
			Appears to see ( ) no strabismus	**Genitalia: Male**			Normal appearance, circ. / uncirc.
Ears			Canals Clear, TMs normal				Testes in scrotum
			Appears to hear	**Female**			No lesions, nl. external appearances
Nose			Passages patent	**Femoral pulses**			Present & equal
Mouth & Pharynx			Normal color, no lesions	**Extremities**			No deformities, full ROM
Neck			Supple, no masses palpated	**Skin**			Clear, no significant lesions
Lymph glands			Nl, not enlarged	**Neurologic**			Alert, moves extremities well

MD Comments: **GUH pamphlet given ( )**

MD Plan:

Next appointment_____ **NP Signature**_____

PASADENA UNIFIED SCHOOL DISTRICT

Nurse Practitioner Physical Evaluation

3 YEARS

Name:_____ DOB:_____ Today's Date: _____

School:_____ Sex:_____ Age:_____ Grade: _____

Height: %	Weight: %	BP:	If ill: Temp:	Heart Rate:	Resp:
Allergies:					

INTERVAL HISTORY

Diet:
Stools:
Sleep Pattern:
Meds/vitamins

IMMUNIZATIONS

DPT/Hib _____ _____ _____ _____ _____

Polio _____ _____ _____ _____ _____

MMR _____ _____ PPD_____ + / –

Hepatitis B_____ Varicella _____

Yes	No	GROWTH DEVELOPMENT	Yes	No	
		Goes up stairs alternating feet			Vocabulary of about 500 words
		Plays with other children			Helps in dressing
		Knows age, sex, first, last name			Copies
		Balance on each foot, 1 second			20 teeth
					Cuts with scissors

CC:_____ HgB: _____

Urine: pH_____ protein_____ glucose_____ ketones_____ blood_____ leukocytes_____ S.G._____

	Yes	No	PHYSICAL EXAMINATION		Yes	No	
General Appearance			Well nourished & developed	Teeth			Grossly Normal 10/10
			No abuse/neglect evident	Heart			No murmurs, regular rhythm
Head			Normocephalic	Chest/Lungs			Breath sounds normal bilaterally, symmetrical
Eyes			Conjunctivae, sclera, pupils normal	Abdomen			Soft, no masses, liver & spleen normal
			Red reflexes present	Genitalia: Male			Normal appearance, circ./uncirc., testes ==
			Appears to see ( ) no strabismus	Female			No lesions, nl. external appearances
Ears			Canals Clear, TMs normal	Spinal Column			Straight
			Appears to hear	Hips			Good abduction
Nose			Passages patent	Pulses			Present & equal bilaterally
Mouth & Pharynx			Normal color, no lesions	Extremities			No deformities, full ROM
Neck			Supple, no masses palpated, full ROM	Skin			Clear, no significant lesions
Lymph Nodes			No palpable	Neurologic			Alert, moves extremities well (see neuro attached)

NP Comments:
NP Plan:

ANTICIPATORY GUIDANCE

- ☐ Diet: Regular meals with snacks, caloric balance, sweets, sodium, iron
- ☐ Behavior: Fast moving, value judgments, very aware of peers
- ☐ Accident prevention: Street dangers, knives, falls, drowning, caution with strangers, smoke detector, hot water temp, window guards, pool fence, play equipment, bike helmet, ipecac, poison center phone no, storage of drugs, toxic chemicals, matches, and guns
- ☐ Guidance: Role of father, B&B problems, stuttering, TV programs, regular exercise, brush teeth, dentist Q 1-2 year, UV skin protection
- ☐ Toddler car seat until 4 years or 40 lbs.
- ☐ Rx for fluoride drops/chewable tabs .50mg/1.0mg QD until age 4
- ☐ Childcare plan
- ☐ Emergency care plan

Next Appointment_____ NP Signature _____

PASADENA UNIFIED SCHOOL DISTRICT
Nurse Practitioner Physical Evaluation

4 - 5 YEARS

Name:_____ DOB:_____ Today's Date: _____

School:_____ Sex:_____ Age:_____ Grade: _____

Height: %	Weight: %	BP:	If ill: Temp: Heart Rate: Resp:
Allergies:			Exposure to infectious diseases

INTERVAL HISTORY

Diet:
Stools:
Sleep Pattern:
Meds/vitamins

IMMUNIZATIONS

DPT/Hib _____ _____ _____ _____ _____
Polio _____ _____ _____ _____ _____
MMR _____ _____ PPD_____ + / –
Hepatitis B_____ Varicella _____

Yes	No	GROWTH DEVELOPMENT	Yes	No	
		Hops on one foot			Plays with several children
		Counts 4 pennies			Recognizes 3-4 colors
		Copies a square			Knows opposites
		Catches, throws a ball			Knows name, address, phone number

CC:_____ HgB: _____

Urine: pH_____ protein_____ glucose_____ ketones_____ blood_____ leukocytes_____ S.G._____

	Yes	No	PHYSICAL EXAMINATION		Yes	No	
General Appearance			Well nourished & developed	Teeth			Grossly Normal
			No abuse/neglect evident	Heart			No murmurs, regular rhythm
Head			Normocephalic	Chest/Lungs			Breath sounds normal bilaterally
Eyes			Conjunctivae, sclera, pupils normal	Abdomen			Soft, no masses, liver & spleen normal
			Red reflexes present, no strabismus	Genitalia: Male			Normal appearance, circ./uncirc., testes ==
			Vision Screen R 20/ L 20/	Female			No lesions, nl. external appearances
Ears			Canals Clear, TMs normal	Spinal Column			Straight
			Audiometric Screen R L	Hips			Good abduction
Nose			Passages patent	Pulses			Present & equal bilaterally
Mouth & Pharynx			Normal color, no lesions	Extremities			No deformities, full ROM
Neck			Supple, no masses palpated, full ROM	Skin			Clear, no significant lesions
Lymph Nodes			No palpable	Neurologic			Alert, moves extremities well (see neuro attached)

NP Comments:
NP Plan:

ANTICIPATORY GUIDANCE

- ☐ Diet: Regular meals with snacks, caloric balance, sweets, Fe, Na, meal socialization, school lunch program
- ☐ Accident prevention: Street dangers, knives, falls, drowning, caution with strangers, smoke detector, hot water temp, window guards, pool fence, play equipment, bike helmet, ipecac, poison center phone no, storage of drugs, toxic chemicals, matches, and guns, burns Guidance:
- ☐ Knows name and address & phone #, plays w/other children, imitates adults, honest & simple answers re: sex, dressing self, B&B problems, stuttering, TV programs, regular exercise, brush teeth, dentist Q 1-2 years, UV skin protection
- ☐ Childcare plan
- ☐ Emergency care plan
- ☐ Seat belt use

Next Appointment_____ NP Signature _____

PASADENA UNIFIED SCHOOL DISTRICT
Nurse Practitioner Physical Evaluation

6, 7, 8 YEARS

Name:_____ DOB:_____ Today's Date: _____

School:_____ Sex:_____ Age:_____ Grade: _____

Height: %	Weight: %	BP:	If ill: Temp: Heart Rate: Resp:
Allergies: Exposure to infectious diseases:			Growth Chart Discussed with Parent: Accidents:

INTERVAL HISTORY

Diet:
Appetite:
Illnesses, stomach, headache:
Fatigue, nightmares, enuresis:

IMMUNIZATIONS

DPT/Hib _____ _____ _____ _____ _____
Polio _____ _____ _____ _____ _____
MMR _____ _____ PPD_____ + / –
Hepatitis B_____ Varicella _____

GROWTH/SCHOOL PROGRESS

Achievement, sports, peer relationship, attendance, school vision or hearing problem:

CC:_____ HgB: _____

Urine: pH_____ protein_____ glucose_____ ketones_____ blood_____ leukocytes_____ S.G._____

	Yes	No	PHYSICAL EXAMINATION		Yes	No	
General Appearance			Well nourished & developed	Breast (female)			No masses, Tanner stage I II III IV V
			No abuse/neglect evident	Lungs			Clear to auscultation bilaterally
Head			No lesions; normocephalic	Abdomen			Soft, no masses, liver & spleen normal
Eyes			PERRLA, Conjunctivae & sclera clear	Genitalia			Grossly nl, Tanner stage I II III IV V
			Vision grossly normal	Male			Circ./uncirc. ( ) testes in scrotum
Ears			Canals Clear, TMs normal	Female			No lesions, nl. external appearances
			Hearing grossly normal	Hips			Good abduction
Nose			Passages clear, MM pink, no lesions	Femoral Pulses			Present & equal bilaterally
Teeth			Grossly Normal	Extremities			No deformities, full ROM
Neck			Supple, no masses, thyroid not enlarged, full ROM	Lymph nodes			Not enlarged
Chest			Symmetrical	Back			Scoliosis
Heart			No organic murmurs, regular rhythm	Skin			Clear, no significant lesions
				Neurologic			Alert, no gross sensory or motor deficit

NP Comments:

NP Plan:

ANTICIPATORY GUIDANCE

- ☐ Diet: Regular meals with snacks, caloric balance, sweets, Fe, Na, meal socialization, school lunch program
- ☐ Rx for fluoride .50/1.0 mg QD till age 16
- ☐ Guidance: Bed time, discipline, smoking, alcohol, marijuana, cocaine, IV & other drugs, early sex education and puberty progress, tooth brushing, regular dental visits Q 6 months, UV skin protection, regular exercise, school achievement, fun, friends, family life education, child sexual abuse

PASADENA UNIFIED SCHOOL DISTRICT
Nurse Practitioner Physical Evaluation

9, 10, 11, 12 YEARS

Name:_____ DOB:_____ Today's Date: _____

School:_____ Sex:_____ Age:_____ Grade: _____

Height: %	Weight: %	BP:	If ill: Temp: Heart Rate: Resp:
Allergies: Exposure to infectious diseases:			Growth Chart Discussed with Parent: Accidents:

INTERVAL HISTORY

Diet/Appetite:
Physical Activity:
Illnesses, stomach, headache:
Tobacco/alcohol/drug use/sexual activity:

IMMUNIZATIONS

DPT/Hib _____ _____ _____ _____ _____
Polio _____ _____ _____ _____ _____
MMR _____ _____ PPD_____ + / –
Hepatitis B_____ Varicella _____

GROWTH/SCHOOL PROGRESS

Achievement, sports, peer relationship (a best friend?), attendance, school vision or hearing problem:

CC:_____ HgB: _____

Urine: pH_____ protein_____ glucose_____ ketones_____ blood_____ leukocytes_____ S.G._____

	Yes	No	PHYSICAL EXAMINATION		Yes	No	
General Appearance			Well nourished & developed	Breast (female)			No masses, Tanner stage I II III IV V
			No abuse/neglect evident	Lungs			Clear to auscultation bilaterally
Head			No lesions; normocephalic	Abdomen			Soft, no masses, liver & spleen normal
Eyes			PERRLA, Conjunctivae & sclera clear	Genitalia			Grossly nl, Tanner stage I II III IV V
			Vision grossly normal	Male			Circ./uncirc. ( ) testes in scrotum
Ears			Canals Clear, TMs normal	Female			No lesions, nl. external appearances
			Hearing grossly normal	Hips			Good abduction
Nose			Passages clear, MM pink, no lesions	Femoral Pulses			Present & equal bilaterally
Teeth			Grossly Normal	Extremities			No deformities, full ROM
Neck			Supple, no masses, thyroid not enlarged, full ROM	Lymph nodes			Not enlarged
Chest			Symmetrical	Back			Scoliosis
Heart			No organic murmurs, regular rhythm	Skin			Clear, no significant lesions
				Neurologic			Alert, no gross sensory or motor deficit

NP Comments:

NP Plan:

ANTICIPATORY GUIDANCE

- ☐ Diet: Limits sweets, sodium, and fat (esp. Sat and cholesterol), snacks, balanced meals
- ☐ Rx for fluoride .50/1.0 mg QD till age 16
- ☐ Accident prevention: bike helmet, water safety, car safety, smoke detector, storage of guns, toxic chemicals, matches
- ☐ Guidance: Bed time, discipline, smoking, alcohol, marijuana, cocaine, IV & other drugs, family life education, early sex education and puberty, regular exercise – 3 times per week, health decisions, TV, school, fun, friends, UV light protection, tooth brushing, dental visits Q 6 months, sexual abuse, violence protection
- ☐ Seat belt use

PASADENA UNIFIED SCHOOL DISTRICT
Nurse Practitioner Physical Evaluation

13, 14, 15, 16 YEARS

Name:_____ DOB:_____ Today's Date: _____

School:_____ Sex:_____ Age:_____ Grade: _____

Height: %	Weight: %	BP:	If ill: Temp:	Heart Rate:	Resp:
Allergies: Exposure to infectious diseases:			Growth Chart Completed: LMP:		

INTERVAL HISTORY (alone/with parent)

Diet:
Appetite:
Physical Activity:
Illnesses, stomach, headache, fatigue:
Sexual activity:

IMMUNIZATIONS

DPT/Hib _____ _____ _____ _____ _____

Polio _____ _____ _____ _____ _____

MMR _____ _____ PPD_____ + / –

Hepatitis B_____ Varicella _____

GROWTH/SCHOOL PROGRESS Achievement, sports, peer relationship, attendance, hobbies, school vision or hearing problem:

CC: _____

_____ HgB: _____

Urine: pH_____ protein_____ glucose_____ ketones_____ blood_____ leukocytes_____ S.G._____

	Yes	No	PHYSICAL EXAMINATION		Yes	No	
General Appearance			Well nourished & developed	Breast (female)			No masses, Tanner stage I II III IV V
			No abuse/neglect evident	Lungs			Clear to auscultation bilaterally
Head			No lesions	Abdomen			Soft, no masses, liver & spleen normal
Eyes			PERRLA, conjunctivae & sclera clear	Genitalia			Grossly nl, Tanner stage I II III IV V
			Vision grossly normal	Male			Circ./uncirc. ( ) testes in scrotum
Ears			Canals Clear, TMs normal	Female			No lesions, nl. external appearances
			Hearing grossly normal	Hips			Good abduction
Nose			Passages clear, MM pink, no lesions	Femoral Pulses			Present & equal bilaterally
Teeth			Grossly Normal	Extremities			No deformities, full ROM
Neck			Supple, no masses, thyroid not enlarged, full ROM	Lymph nodes			Not enlarged
				Back			Scoliosis
Chest			Symmetrical	Skin			Clear, no significant lesions
Heart			No organic murmurs, regular rhythm	Neurologic			Alert, no gross sensory or motor deficit

NP Comments:
NP Plan:

ANTICIPATORY GUIDANCE

- ☐ Diet: Fat (esp. sat and cholesterol), Na, Fe, Ca, caloric balance, appropriate weight, junk food, eating disorders
- ☐ Rx for fluoride .50/1.0 mg QD till age 14
- ☐ Accident prevention: Safety helmet, risk taking behavior, DUI, guns, violent behavior, motor vehicle safety, work safety. Guidance:
- ☐ Smoking, alcohol, marijuana, cocaine, IV and other drugs, depression, suicidal ideation, puberty progress, sex education (partner selection, condoms, contraception, AIDS risk factors), goals in life, family interaction
- ☐ Seat belt use
- ☐ Personal development; physical, growth, sexuality, independence
- ☐ Testicular self exam
- ☐ Breast Self Exam

Next Appointment_____ NP Signature _____

PASADENA UNIFIED SCHOOL DISTRICT
Nurse Practitioner Physical Evaluation

17, 18, 19, 20 YEARS

Name:_____ DOB:_____ Today's Date: _____

School:_____ Sex:_____ Age:_____ Grade: _____

Height: %	Weight: %	BP:	If ill: Temp:	Heart Rate:	Resp:
Allergies: Exposure to infectious diseases:			LMP:		

INTERVAL HISTORY (alone/with parent)

Diet:
Appetite:
Physical Activity:
Illnesses, stomach, headache, fatigue:
Sexual activity:

IMMUNIZATIONS

DPT/Hib _____ _____ _____ _____ _____

Polio _____ _____ _____ _____ _____

MMR _____ _____ PPD_____ + / –

Hepatitis B_____ Varicella _____

GROWTH/SCHOOL PROGRESS Achievement, sports, peer relationship, attendance, hobbies, school vision or hearing problem:

CC: _____

_____ HgB: _____

Urine: pH_____ protein_____ glucose_____ ketones_____ blood_____ leukocytes_____ S.G._____

	Yes	No	PHYSICAL EXAMINATION		Yes	No	
General Appearance			Well nourished & developed	Breast (female)			No masses, Tanner stage I II III IV V
			No abuse/neglect evident	Lungs			Clear to auscultation bilaterally
Head			No lesions	Abdomen			Soft, no masses, liver & spleen normal
Eyes			PERRLA, conjunctivae & sclera clear	Genitalia			Grossly nl, Tanner stage I II III IV V
			Vision grossly normal	Male			Circ./uncirc. ( ) testes in scrotum
Ears			Canals Clear, TMs normal	Female			No lesions, nl. external appearances
			Hearing grossly normal	Hips			Good abduction
Nose			Passages clear, MM pink, no lesions	Femoral Pulses			Present & equal bilaterally
Teeth			Grossly Normal	Extremities			No deformities, full ROM
Neck			Supple, no masses, thyroid not enlarged, full ROM	Lymph nodes			Not enlarged
				Back			Scoliosis
Chest			Symmetrical	Skin			Clear, no significant lesions
Heart			No organic murmurs, regular rhythm	Neurologic			Alert, no gross sensory or motor deficit

NP Comments:
NP Plan:

ANTICIPATORY GUIDANCE

- ☐ Diet: Obesity, eating disorders, junk food
- ☐ Accident prevention: Safety helmet, risk taking behavior, DUI, guns, violent behavior, motor vehicle safety, work safety.
- ☐ Guidance: Smoking, alcohol, marijuana, cocaine, IV and other drugs, suicidal ideation, puberty progress, sex education (partner selection, condoms, contraception, AIDS risk factors), goals in life, regular exercise
- ☐ Seat belt use
- ☐ Personal development, independence
- ☐ Academic, work activities
- ☐ Family, social interaction, communication
- ☐ Personal development: physical, growth, sexuality, independence
- ☐ Testicular self exam
- ☐ Breast Self Exam

Next Appointment_____ NP Signature _____

HEADS ASSESSMENTS

HOME Family Structure Relationships/Communication with parents and sibling, privacy Violence (Domestic) Discipline	
EDUCATION Grades Study Habits Goals Attitude towards school Friends, Influence	
ACTIVITES Extracurricular Religious Activities Gangs TV. Video/Computer & Games	
DRUGS Illicit (IV risks) Legal (ETOH Tobacco) Medications Narcotics Marijuana	
SEX Sexual Activity Gender Preference No. of Partners Protection (Condoms) Knowledge and Safety STD with Risks (Identify)	
SUICIDE Mood Suicidal Ideation Attempt/plan/exposure Cult Activities/devil worship Satanism	

Child's Last Name	First Name	M.I.	Age	Date of Birth

Approved CHDP Screening Audiogram

	Right Ear				Left Ear			
	1000	2000	3000	4000	1000	2000	3000	4000
Date of 1st Screen _____								
Date of 2nd Screen _____								

Δ	A check mark indicates that the child responded at the level of 25db.
—	A dash mark indicates that the child did not respond at the level of 25db.

Vision Screening

TYPE OF TEST:

Snellen E	
Snellen Letters	
Symbol Chart	
Allen Picture Card Test	

Date of 1st Screen _____	**20 /**	**20 /**
	Right Eye	Left Eye
Date of 2nd Screen _____	**20 /**	**20 /**
	Right Eye	Left Eye

Comments: _____

Referred to: _____

CLASSIFIED_____

CERTIFICATED_____

PASADENA UNIFIED SCHOOL DISTRICT
HEALTH PROGRAMS

EMPLOYEE MANTOUX TEST

Name _____ Social Security No _____

Address _____

City_____Zip_____Telephone _____

Age:_____ Sex: Female ☐ Male ☐

Job Title_____Work Location _____

TUBERCULOSIS QUESTIONNAIRE

1. My last Mantoux TB test was: Negative_____ Positive _____
2. In the past I have been required to have a chest X-ray because of a positive Mantoux test

   ☐ YES ☐ NO

3. I have completed preventive therapy (taken INH medication) for a positive Mantoux test.

   ☐ YES ☐ NO

_____ _____

Employee Signature Date

MANTOUX TEST

Date Given _____

Date of Reading _____

Results _____ MM

Referred for chest X-ray _____
Date

NUTRITION

Screening and Evaluation at a Glance DHS Form 4035A Instructions available at:

http://www.dhcs.ca.gov/formsandpubs/forms/Forms/ChildMedSvcForms/dhcs4035AInstructions.pdf

What Does Your Child Eat? English/Spanish/Vietnamese form available at:

http://www.dhcs.ca.gov/formsandpubs/forms/Forms/ChildMedSvcForms/dhcs4035a.pdf

http://www.dhcs.ca.gov/formsandpubs/forms/Forms/ChildMedSvcForms/dhcs4035ASpanish.pdf

http://www.dhcs.ca.gov/formsandpubs/forms/Forms/ChildMedSvcForms/dhcs4035AVietnamese.pdf

What do you eat? (ages 8-21) available at:

http://www.dhcs.ca.gov/formsandpubs/forms/Forms/ChildMedSvcForms/dhcs4466.pdf

Other CHDP Forms and Publications available at:

http://www.dhcs.ca.gov/formsandpubs/forms/Pages/CHDPForms.aspx

PASADENA UNIFIED SCHOOL DISTRICT

CHILDHOOD LEAD POISONING EVALUATION QUESTIONNAIRE

The following questions are to be answered by the parents/guardians of CHDP eligible children under 72 months of age at each periodic health assessment.

1. Does your child live in or regularly visit a house or other location with peeling or chipping paint built before 1960? (This can include a day care center, preschool, school, barn, home of babysitter, relative, friend, etc.)

   ☐ Yes ☐ No

2. Does your child live in or regularly visit a house built before 1960 with recent or ongoing renovation or remodeling?

   ☐ Yes ☐ No

3. Does your child have a parent, brother, sister, housemate, or playmate who is being treated or followed for lead poisoning (i.e., blood lead ≥ 10 ug/dL)?

   ☐ Yes ☐ No

4. Does your child live with someone whose job or hobby involves exposure to lead (i.e., painting, soldering, automobile battery manufacturing or recycling, vehicle radiator repair)?

   ☐ Yes ☐ No

5. Does your child live near an active lead smelter or battery recycling plant or other industry likely to release lead?

   ☐ Yes ☐ No

I hereby give my consent for my son/daughter to receive a venipuncture blood lead test (Drawing blood from a vein).

_____ _____
Child's Name Birth Date

_____ _____
Parent's Signature Date

I refuse to have my child have the venipuncture blood lead test.

_____ _____
Parent's Signature Date

SIMPLE THINGS
THAT YOU CAN DO TO
PREVENT CHILDHOOD LEAD POISONING

NEVER SAND, BURN OR SCRAPE PAINT unless you know that it does not contain lead.

ALWAYS TEST PAINT FOR LEAD in any area that you plan to remodel before you begin the work. If lead is in the paint, do not begin work until you learn safe paint handling methods. Improperly handling lead paint can scatter lead dust and poison your family, workers and neighbors.

TRY TO KEEP YOUR HOME AS FREE FROM DUST AS POSSIBLE. Mop floors often with water and household detergent. Do not sweep or vacuum floors because this will spread the dust around and not contain it. This is not a permanent solution and does not remove the danger of having lead paint in your home.

DO NOT put cribs, playpens, beds or high chairs next to areas where paint is chipping or peeling.

ALWAYS CHANGE YOUR WORK CLOTHES and take a shower before coming home, if you work with lead such as in a radiator repair shop, or a battery manufacturing plant. Wash work clothes separately from other clothes. If you do work with lead and have questions, you can call (510) 540-3010. You may call collect.

ALWAYS TAKE OFF SHOES BEFORE ENTERING THE HOUSE. This will prevent lead dust and soil from getting into the house.

DO NOT USE HOME REMEDIES OR COSMETICS THAT CONTAIN LEAD like Azarcon, Greta, Pay-loo-ah, and alkohl or kohl.

DO NOT USE IMPORTED OR HAND-MADE DISHES for serving, preparing or storing food or drink. They may contain lead.

AVOID HOBBIES THAT USE LEAD. Hobbies that use lead include soldering, or stained glass, bullets, or fishing sinkers.

ENCOURAGE children to wash their hands before eating.

ENCOURAGE HEALTHY EATING HABITS. A child without a balanced diet may be hurt by lead more easily. Meals should include fruits, vegetables as well as calcium-rich foods (mild, cheese, yogurt, tofu or bean curd) and iron rich foods (meat, chicken, iron-fortified cereals, raisins and eggs).

COSAS SIMPLES QUE UD.
PUEDE HACER PARA PREVENIR
EL ENVENENAMIENTO DE PLOMO EN LOS NIÑOS

NUNCA LIJE, QUEME O RASPE LA PINTURA al menos que Ud. sepa que no contiene plomo.

SIEMPRE EXAMINE LA PINTURA PARA SABER SI CONTIENE PLOMO, ANTES DE COMENZAR EL TRABAJO, si es que Ud. planea remodelar algún área de su casa. Si descubre que la pintura contiene plomo, no empiece el trabajo hasta que Ud. sepa de un método seguro para manejar la pintura. Si Ud. maneja impropiamente una pintura que contenga plomo, puede desparramar el polvo de plomo y causar el envenenamiento de su familia, de los trabajadores y de sus vecinos.

TRATE DE MANTENER SU CASA LO MAS LIBRE DE POLVO POSIBLE. Limpie el piso con agua y detergente. No barra o use la aspiradora en el piso, porque desparramará el polvo por todos lados sin contenerlo. Esta no es una solución permanente, y no elimina el peligro de tener la pintura que contiene plomo en su casa.

NO PONGA las cunas, corralitos para bebés, camas, o sillas altas para bebés, cerca de las áreas donde la pintura se está pelando o resquebrajando.

SIEMPRE CAMBIE SU ROPA DE TRABAJO y tome una ducha antes de venir a casa si es que Ud. trabaja con plomo, como por ejemplo, en un taller donde reparan rediadores, o en una fábrica de bateriás. Lave las ropas de trabajo separadamente de las otras ropas. Si Ud. trabaja con plomo y tiene preguntas, puede llamar al teléfono # (510) 540-3014. Ud. puede llamar por cobrar (collect).

SIEMPRE QUITESE LOS ZAPATOS ANTES DE ENTRAR A LA CASA. Esto previene que Ud. lleve el polvo y tierra adentro de la casa.

NO USE REMEDIOS O COSMETICOS QUE CONTENGAN PLOMO, como el Azarcón, Gretah, Pay-loo-ah y Alkohl o Kohl.

NO USE PLATOS QUE SEAN IMPORTADOS O HECHOS A MANO para servir, preparar, o guardar comidas o bebidas. Pueden contener plomo.

EVITE LOS PASATIEMPOS (Hobbies) QUE REQUIEREN QUE UD. USE PLOMO. Aquellos pasatiempos que requieren plomo son: soldar, hacer cuadros de vidrios pintados, hacer balas, o las pesas para las cañas de pescar.

ANIME A LOS NINOS A QUE SE LAVEN LAS MANOS antes de comer.

FOMENTE HABITOS SALUDABLES PARA COMER. Un niño sin una dieta balanceada será afectado mas facilmente por el plomo. Las comidas deben incluir frutas y verduras, tambien comidas ricas en calcio (leche, quesos, yogur, tófu o queso de frijoles), y comidas ricas en hierro, como la carne de res, pollo, cereales fortificados con hierro, pasas de uvas y huevos.

Pasadena Unified School District
Nurse Practitioner Policy and Procedures

1. All nurse practitioners will stay within the approved protocols for pediatric care. CHDP guidelines should be followed for routine physical examinations.

2. All questions regarding CHDP policies and procedures should be referred to Dr. Harold Wilson.

3. All questions regarding episodic care should be referred to Dr. Wilson.

4. Dr. Wilson will review all charts resulting from episodic visits. The charts will be held at each site of care.

5. The nurse practitioner has the responsibility of notifying Dr. Wilson when the number of episodic visits for review total 10 or more. An 'on-site' chart review will be scheduled at a time mutually agreed upon by the nurse practitioner and Dr. Wilson. In the event that the total number of charts remains less than 10, the charts will be reviewed twice annually.

6. All students requiring medical assistance will be triaged by the nurse practitioners at the district clinic at the Education Center

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