

1 **Education Cabinet**

2 **Kentucky Board of Education**

3 **Department of Education**

4 **(Amendment) (Establish 702 KAR 0.000)**

5 **702[4] KAR 0:000 [4:020]. School health services.**

6 RELATES TO: KRS 156.160(1)(g), (h), (i), (156.501), 156.502, 161.145, 214.034, (214.036), 29

7 C.F.R. 1910.1030

8 STATUTORY AUTHORITY: KRS 156.070, 156.160(1)

9 NECESSITY, FUNCTION, AND CONFORMITY: KRS 156.160(1) (g) requires the Kentucky  
10 Board of Education to promulgate administrative regulations governing medical inspection,  
11 physical and health education and recreation, and other administrative regulations deemed  
12 necessary or advisable for the protection of the physical welfare and safety of the public school  
13 children. KRS 156.160 (h) and (i) require the board to promulgate administrative regulation  
14 governing a required vision examination and a dental screening or examination. This  
15 administrative regulation establishes standards and criteria for preventative health care  
16 examinations at the local school district level.

17 Section 1. School Employee Medical Examinations. (1) Except as provided in subsection (2) of  
18 this section, a local board of education shall require a medical examination of each certified or  
19 classified employee, including each substitute teacher, that:

20 (a) Is conducted prior to initial employment; and

1 (b) Includes a tuberculosis (TB) risk assessment 1. If the individual is identified by that  
2 assessment as being at high risk for TB, the individual shall be required to undergo the  
3 administration of a tuberculin skin test (TST).

4 2. The TB risk assessment shall be performed and reported by a physician, an advanced  
5 registered nurse practitioner, a physician's assistant, or a registered nurse.

6 (2) The medical examination requirement shall not apply to school bus drivers who are covered  
7 by 702 KAR 5:080.

8 (3) A local board of education may require by policy that a school employee physical  
9 examination be conducted no earlier than a ninety (90) day period prior to initial employment.

10 (4) A medical examination shall be reported on the form, "Medical Examination of School  
11 Employees", KDESHS001.

12 (5) A person who tests positive for TB shall be required to comply with the directives of the local  
13 board of health and the Kentucky Department for Public Health for further evaluation and  
14 treatment of the TB infection.

15 (6)(a) Following the required medical examination for initial employment and any subsequent  
16 examinations as may be required for positive tuberculin reactors, a school district employee other  
17 than a bus driver shall submit to the local school superintendent the completed Medical  
18 Examination of School Employees form required by subsection (4) of this section.

19 (b) The medical examination shall be performed and signed for by a physician, physician  
20 assistant, or an advanced practice registered nurse [practitioner].

1 (7) Documentation of a TST [~~tuberculin skin test~~] and chest x-ray, if performed, shall include:

2 (a) The date given;

3 (b) Type of test;

4 (c) Millimeters of induration;

5 (d) Date read and by whom; and

6 (e) Date x-ray taken and results as related to TB [~~tuberculosis~~] status.

7 (8)(a)1. A local board of education shall require all school personnel exhibiting symptoms of  
8 chronic respiratory disease to undergo a TB [~~tuberculosis (TB)~~] risk assessment and  
9 examinations as indicated.

10 2. The evaluation and any recommended treatment for TB [~~tuberculosis~~] infection shall be based  
11 upon the directives of the local board of health and the Kentucky Department for Public Health.

12 (b) An employee exposed to infectious TB [~~tuberculosis~~] shall be tested and, if necessary, treated  
13 for TB [~~tuberculosis~~] infection according to the directives of the local board of health.

14 (c) In a county with an incidence of cases of active TB [~~tuberculosis~~] that is equal to or greater  
15 than the national average as established by the Department for Public Health, Division of  
16 Epidemiology, Tuberculosis Control Program, the local board of health may, with the approval  
17 of the Kentucky Department for Public Health, require more extensive testing of school district  
18 employees for TB [~~tuberculosis~~].

19 Section 2. Preventative Health Care Examinations. (1)(a) A local board of education shall require  
20 a preventative health care examination.

1 (b) A second examination shall be required within one (1) year prior to entry into the sixth grade.

2 (c) A third examination may be required by policy of the local board of education within one (1)  
3 year prior to entry into the ninth grade.

4 (2) An out-of-state transfer student shall be required to submit documentation of a preventative  
5 health care examination.

6 (3) A local school board may extend the deadline by which to obtain a preventative health care  
7 examination, not to exceed two (2) months.

8 (4) [(3)] A preventative health care examination shall be performed and signed for by a  
9 physician, an advanced practice registered nurse [~~practitioner~~], a physician's assistant, or by a  
10 health care provider in the early periodic screening diagnosis and treatment programs.

11 (5) [(4)] A preventative health care examination shall be reported on the [~~form~~] Preventative  
12 Health Care Examination Form, KDESHS002 and shall include:

13 (a) A medical history;

14 (b) An assessment of growth and development and general appearance;

15 (c) A physical assessment including hearing and vision screening; and

16 (d) Recommendations to the school regarding health problems that may require special attention  
17 in classroom or physical education activities.

18 (6) [(5)] (a) A vision examination shall be reported on the form, Kentucky Eye Examination  
19 Form for School Entry, [~~-~~] KDESHS004.

- 1 (b) A dental screening or examination shall be reported on the form, Kentucky Dental  
2 Screening/Examination Form for School Entry, [-] KDEDSE004.
- 3 (7) [(6)] A record of immunization shall be submitted on an Immunization Certificate Form,  
4 EPID 230.
- 5 (8) [(7)] A local school district shall establish a plan for implementation and compliance required  
6 for the sixth grade preventative health care examination.
- 7 (9) [(8)] A current [valid] Immunization Certificate Form, EPID 230, shall be on file within two  
8 (2) weeks of the child's enrollment in school.
- 9 (10) [(9)] (a) A board of education shall adopt a program of continuous health supervision for all  
10 school enrollees.
- 11 (b) Supervision shall include scheduled, appropriate screening tests for vision[;] and hearing[,  
12 and scoliosis.].
- 13 [~~(10) A local spinal screening program for scoliosis, pursuant to subsection (10)(b) of this~~  
14 ~~section, shall include:~~
- 15 ~~(a) Training sessions for teachers or lay volunteers who will be doing the screening;~~  
16 ~~(b) Obtaining parental permission for scoliosis screening;~~
- 17 ~~(c) Established screening times, at least in grades six (6) and eight (8) and appropriate procedures~~  
18 ~~and referral criteria;~~
- 19 ~~(d) Mandated education of students regarding scoliosis screening; and~~

1 ~~(e) Required referral of all children with abnormal screening results for appropriate diagnosis~~  
2 ~~and treatment and follow-up on these referrals. Local referral and follow-up procedures shall~~  
3 ~~include:~~

- 4 ~~1. Notification of parents of students who need further evaluation by a physician;~~
- 5 ~~2. Tracking referrals to determine whether all children with abnormal screening results receive~~  
6 ~~appropriate diagnosis and treatment; and~~
- 7 ~~3. Reporting of data on screening, referral, and follow-up tracking to the Department of~~  
8 ~~Education.~~

9 ~~(11) The Department of Education shall:~~

- 10 ~~(a) Monitor the spinal screening and referral programs provided by local boards of education;~~
- 11 ~~(b) Provide consultation and technical assistance to local school districts concerning spinal~~  
12 ~~screening, referral, and follow-up for appropriate diagnosis and treatment; and~~
- 13 ~~(c) Encourage local school districts to work cooperatively with local health departments and~~  
14 ~~local Commission for Children with Special Health Care Needs offices to plan, promote, and~~  
15 ~~implement scoliosis screening programs.~~

16 ~~(12) Referral and appropriate follow-up of any abnormality noted by a screening assessment or~~  
17 ~~teacher observation shall be recorded on school health records.~~

18 ~~(11)[(13)] A school shall have emergency care procedures, which shall include:~~

- 19 ~~(a) First aid facilities, including provisions for designated areas for the child to recline;~~

1 (b) A requirement that whenever children are present during school hours, there shall be at least  
2 one (1) adult present in the school who is certified in a standard first aid course which includes  
3 CPR for infants and children;

4 (c) A number at which parents can be reached;

5 (d) The name of a family physician.

6 (12) ~~[(14)]~~ A local board of education shall require immunizations as required by KRS 214.034.

7 Section 3. Cumulative Health Records. (1) A school shall initiate a cumulative health record for  
8 each pupil entering its school.

9 (a) The record shall be maintained throughout the pupil's attendance.

10 (b) The record shall be uniform and shall be on the form "Pupil's Cumulative Health Record  
11 KDESHS006" or the record shall be maintained electronically in the student information system.

12 (c) The record shall include screening tests related to growth and development, vision, hearing[5]  
13 and dental, ~~[and sealiosis]~~ and findings and recommendations of a physician and a dentist.

14 (d) A follow-up by the proper health or school authorities shall be made on each abnormality  
15 noted, and the result shall be recorded.

16 (2) A local school authority shall report all known or suspected cases of communicable disease  
17 immediately to the local health department.

18 Section 4. Physical Environment. (1) A board of education shall provide and maintain a physical  
19 environment that is conducive to the health and safety of school children in each school under its  
20 jurisdiction.

- 1 (2) A local board of education shall comply with current laws and administrative regulations  
2 applicable to all public buildings pertinent to health, sanitation, and safety.
- 3 (3) A local board of education shall establish and maintain:
- 4 (a) An adequate supply of water of safe, potable, sanitary quality;
- 5 (b) A state-approved sanitary disposal of sewage, other water carried waste, and solid waste;
- 6 (c) Adequate toilet and lavatory facilities, including soap or detergent as well as towels or other  
7 methods for drying hands, and other sanitary fixtures;
- 8 (d) Adequate heating, lighting, and ventilation in all school buildings;
- 9 (e) Adequate facilities and equipment for cafeterias and lunchrooms;
- 10 (f) Supervision of general sanitation and safety of the school buildings, grounds, and playground  
11 equipment;
- 12 (g) Beginning with the 2010-2011 school year, proof that all unlicensed school personnel who  
13 have accepted delegation to perform medication administration in school have completed a  
14 training course provided by the Kentucky Department of Education. This course shall be  
15 developed in consultation with the Kentucky Board of Nursing to ensure compliance with 201  
16 KAR 20:400;
- 17 (h) Adequate control of air pollutants; and
- 18 (i) Universal precautions guidelines compatible with Occupational Safety and Health  
19 Administration requirements established in 803 KAR 2:320 and 29 C.F.R. 1910.1030.
- 20 Section 5. A superintendent shall designate a person to serve as local district health coordinator.

1 (1) The person designated shall meet the minimum qualifications required of this position as  
2 determined by the Educational Professional Standards Board in 16 KAR 4:010 or by the  
3 Kentucky Department of Education in the Local District Classification Plan for Class Code:  
4 7271.

5 (2) Class Title: Local District Health Coordinator. The local district health coordinator shall  
6 work in cooperation with all school personnel, the local board of education, the State Department  
7 of Education, the local health department, family resource and youth services centers, and  
8 parents in planning, promoting, and implementing a school health services program.

9 Section 6. Incorporation by Reference. (1) The following material is incorporated by reference:

- 10 (a) "Medical Examination of School Employees", KDESHS001 [~~October 2007~~];  
11 (b) "Preventative Health Care Examination Form", KDESHS002 [~~December 1999~~];  
12 (c) "Pupil's Cumulative Health Record", KDESHS006 [~~January 1993~~];  
13 (d) "Local District Classification Plan", "Class Code: 7271, Class Title: Local District Health  
14 Coordinator", December 1999;  
15 (e) "Kentucky Eye Examination Form for School Entry", KDESHS004 [~~August 2000~~];  
16 [~~(f) "Immunization Certificate Form", EPID 230, [October 2007]; ]and  
17 [~~(f) [(g)] "Kentucky Dental Screening/Examination [(F)]or School Entry", KDESHS005 [August~~  
18 ~~2010].~~~~

19 (2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at  
20 the Division of District Support [Nutrition and Health Services], Department of Education, 500

1 ~~Mero Street 2545 Lawrenceburg Road~~, Frankfort, Kentucky 40601, Monday through Friday, 8  
2 a.m. to 4:30 p.m. (SBE 48.011; 1 Ky.R. 81; eff. 11-13-1974; Am. 5 Ky.R. 1086; eff. 8-1-1979; 7  
3 Ky.R. 28; eff. 9-3-1980; 8 Ky.R. 1162; 9 Ky.R. 114; eff. 6-22-1982; 1315; eff. 7-6-1983; 17 Ky.R.  
4 2245; eff. 3-13-1991; 18 Ky.R. 1202; 2256; eff. 1-10-1992; 19 Ky.R. 2494; 20 Ky.R. 75; 509; eff.  
5 8-5-1993; 26 Ky.R. 1449; eff. 3-10-2000; 27 Ky.R. 1332; eff. 1-15-2001; 34 Ky.R. 628; 1421; eff.  
6 1-4-2008; 36 Ky.R. 653; 1218; eff. 1-4-2011.

**KENTUCKY DEPARTMENT OF EDUCATION  
MEDICAL EXAMINATION OF SCHOOL EMPLOYEES\***

1e \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M  F

Address \_\_\_\_\_ Telephone \_\_\_\_\_

Applicant With or Employed By \_\_\_\_\_ Board of Education \_\_\_\_\_

**HISTORY**

**Medical** (All serious medical and psychiatric diseases: diabetes, epilepsy, heart disease, etc.) \_\_\_\_\_

**Surgical** (All major operations) \_\_\_\_\_

*"Per the Genetic Information Nondiscrimination Act of 2008, it is unlawful for an employer to request genetic information, genetic testing information, family medical history information, or family genetic testing information from an applicant or employee. The medical provider conducting this examination of an applicant/employee of a local school district shall not request, require or purchase this information about the applicant or employee. Any applicant or employee undergoing a medical examination for employment with a local school district shall not provide this information to the medical provider or the school district."*

**PHYSICAL**

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

**Tuberculosis Risk Factor Assessment**

- Yes  No  High risk for Tuberculosis infection
- Yes  No  Referred to local health department for further TB infection evaluation
- Yes  No  Tuberculosis test performed (specify: \_\_\_\_\_ TST/ \_\_\_\_\_ BAMT)
- \_\_\_\_\_ Date of chest X-Ray
- No further follow-up unless signs/symptoms of Tuberculosis infection develop

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

\_\_\_\_\_  
Date of Examination

\_\_\_\_\_  
Signature (Physician/PA/ARNP)

\* School Bus Drivers are required to use form TC94-35E.

**KENTUCKY DEPARTMENT OF EDUCATION  
MEDICAL EXAMINATION OF SCHOOL EMPLOYEES\***

Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M  F

Address \_\_\_\_\_ Telephone \_\_\_\_\_

Applicant With Or Employed By \_\_\_\_\_ Board of Education \_\_\_\_\_

**HISTORY**

**Medical** (All serious medical and psychiatric diseases: Diabetes, Epilepsy, Heart Disease, etc.) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Surgical** (All major operations) \_\_\_\_\_  
\_\_\_\_\_

**Family History** (T.B., epilepsy, Diabetes, etc.) \_\_\_\_\_  
\_\_\_\_\_

**PHYSICAL**

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

**Tuberculosis Risk Factor Assessment**

- Yes  No  High risk for Tuberculosis infection
- Yes  No  Referred to local health department for further TB infection evaluation
- Yes  No  Tuberculosis test performed (specify: \_\_\_\_\_ TST/\_\_\_\_\_ BAMT)  
\_\_\_\_\_ Date of chest X-Ray
- No further follow-up unless signs/symptoms of Tuberculosis infection develop

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

\_\_\_\_\_  
Date of Examination

\_\_\_\_\_  
Signature (Physician/PA/ARNP)

\* A separate form is provided for bus drivers

**PREVENTATIVE HEALTH CARE EXAMINATION FORM**

All local boards of education shall require a preventative health care examination of each child first entering a Kentucky public school within a period of twelve (12) months prior to initial admission to school within one (1) year prior to entry to sixth grade. Local school boards may extend this time not to exceed two (2) months. (704 KAR 4:020)

**PLEASE COMPLETE THE IDENTIFYING INFORMATION AND RECORDS**

**IDENTIFYING INFORMATION**

Student Name: \_\_\_\_\_ Gender: M F Grade: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ yrs \_\_\_\_\_ months Preferred Language: \_\_\_\_\_

Parent or Guardian Name: \_\_\_\_\_

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

**MEDICAL HISTORY**

Allergies: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Current Prescribed Medications to be taken daily at school: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Significant Historical Information: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**SCREENING RESULTS:**

Height: \_\_\_\_\_ ft \_\_\_\_\_ inches Weight \_\_\_\_\_ BMI: \_\_\_\_\_ BMI% \_\_\_\_\_ B/P: \_\_\_\_\_

Vision	Right 20/ _____	Passed <input type="checkbox"/>	Hearing - Right	Passed <input type="checkbox"/>	Failed <input type="checkbox"/>	Referred <input type="checkbox"/>
	Left 20/ _____	Failed <input type="checkbox"/>		Hearing - Left	Passed <input type="checkbox"/>	Failed <input type="checkbox"/>
		Referred <input type="checkbox"/>				

Optional: Hct/HGB: \_\_\_\_\_ Lead: \_\_\_\_\_ Urinalysis: \_\_\_\_\_

Gross dental (teeth and gums)  Normal  Abnormal \_\_\_\_\_ Refer/Tx: \_\_\_\_\_  
 Head/scalp/skin  Normal  Abnormal \_\_\_\_\_ Refer/Tx: \_\_\_\_\_  
 Eyes/Ears/Nose/Throat  Normal  Abnormal \_\_\_\_\_ Refer/Tx: \_\_\_\_\_  
 Chest/Lungs/Heart  Normal  Abnormal \_\_\_\_\_ Refer/Tx: \_\_\_\_\_  
 Abdomen  Normal  Abnormal \_\_\_\_\_ Refer/Tx: \_\_\_\_\_  
 Scoliosis assessment  Normal  Abnormal \_\_\_\_\_ Refer/Tx: \_\_\_\_\_

This child has the following problems that may impact the educational experience:

- Vision  Hearing  Speech/Language  Physical  Social/Behavioral  Cognitive

Specify: \_\_\_\_\_  
 \_\_\_\_\_

PREVENTATIVE HEALTH CARE EXAMINATION FORM - INITIAL ENTRY [headstart - fourth (4) grade]

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

PLEASE COMPLETE THE IDENTIFYING INFORMATION AND RECORDS

IDENTIFYING INFORMATION

Student Name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent or Guardian Name: \_\_\_\_\_

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

MEDICAL HISTORY

Seizures: \_\_\_\_\_

Chronic Illness: \_\_\_\_\_

Allergies: \_\_\_\_\_

Medications: \_\_\_\_\_

Significant Historical Information: \_\_\_\_\_

Physical Exam:

N.	Abn.	
_____	_____	General Appearance
_____	_____	HEENT
_____	_____	Skin
_____	_____	Neck
_____	_____	Chest
_____	_____	Heart
_____	_____	Abd - Genitalia
_____	_____	Extremities-Back
_____	_____	Neuro

Hgt: \_\_\_\_\_ Wgt: \_\_\_\_\_ BP: \_\_\_\_\_ / \_\_\_\_\_  
 Hearing: R \_\_\_\_\_ L \_\_\_\_\_  
 Vision: R \_\_\_\_\_ / \_\_\_\_\_ L \_\_\_\_\_ / \_\_\_\_\_  
 STRABISMUS/AMBLYOPIA SCREEN  ABNORMAL  
 Optional-----HCT/HGB: \_\_\_\_\_ (required for headstart)  
 Optional-----UA: \_\_\_\_\_

Explain Abnormal Exam: \_\_\_\_\_

Recommendations:

\_\_\_\_\_ No Restrictions: Normal Exam

\_\_\_\_\_ RESTRICTIONS AND SUGGESTIONS TO SCHOOL: \_\_\_\_\_

Age appropriate and suggested anticipatory guidance (health assessments)

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

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Physician/ARNP/PA/EPST Provider

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

Kentucky Department of Education

PREVENTATIVE HEALTH CARE EXAMINATION FORM - Sixth (6<sup>th</sup>) Grade Form (for grades 5-12)

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

PLEASE COMPLETE THE IDENTIFYING INFORMATION AND RECORDS

IDENTIFYING INFORMATION

Grade: 5<sup>th</sup> 6<sup>th</sup> 7<sup>th</sup> 8<sup>th</sup> 9<sup>th</sup> 10<sup>th</sup> 11<sup>th</sup> 12<sup>th</sup> (Circle appropriate grade)

Student Name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent or Guardian Name: \_\_\_\_\_

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

MEDICAL HISTORY

Seizures: \_\_\_\_\_

Chronic Illness: \_\_\_\_\_

Allergies: \_\_\_\_\_

Medications: \_\_\_\_\_

Significant Historical Information \_\_\_\_\_

Physical Exam:

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

Explain Abnormal Exam: \_\_\_\_\_

Recommendations:

\_\_\_\_\_ No Restrictions: Normal Exam

\_\_\_\_\_ RESTRICTIONS AND SUGGESTIONS TO SCHOOL: \_\_\_\_\_

Age Appropriate and Suggested Anticipatory Guidance (Health Assessments)

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

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

Risk behaviors were discussed and addressed

Risk behaviors were not addressed today

Signed: \_\_\_\_\_ Date \_\_\_\_\_

Physician/ARNP/PA/EPSTDT Provider

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

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

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

KRS 156.160 (1) (g) requires proof of a vision examination by an optometrist or ophthalmologist. This evidence shall be submitted to the school no later than January 1 of the first year that a three (3), four (4), five (5) or six (6) year old child is enrolled in public school, public preschool, or Head Start program.

**PLEASE COMPLETE THE IDENTIFYING INFORMATION**

Date of student's enrollment: \_\_\_\_\_

Date of Vision Examination: \_\_\_\_\_

**IDENTIFYING INFORMATION**

Student Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Parent or Guardian Name: \_\_\_\_\_

**CASE HISTORY**

Date of Exam: \_\_\_\_\_

Ocular History: Normal or Positive for: \_\_\_\_\_

Medical History: Normal or Positive for: \_\_\_\_\_

Drug Allergies: NKDA or Allergic to: \_\_\_\_\_

Family Ocular and Medical History:  Amblyopia  Strabismus  Glaucoma  Diabetes

Other: \_\_\_\_\_

Other Pertinent Information: \_\_\_\_\_

Refraction with cycloplegic? (Please indicate one.)  YES  NO

	OD	OS
Unaided Acuity	20/	20/
Best Corrected Acuity	20/	20/

Type of Examination	Normal	Abnormal	Notable to Assess
External Exam (eye and adnexa)			
Internal Exam (media, lens, fundus, etc)			
Neurological Integrity (pupils)			
Binocular Function (stereopsis)			
Accommodation and convergence			
Color Vision			

**Diagnosis:**

Normal  Myopia  Hyperopia  Astigmatism  Strabismus  Amblyopia

Other: \_\_\_\_\_

**Recommendations:**

1 Glasses prescribed:  YES  NO

2 \_\_\_\_\_

3 \_\_\_\_\_

**Age appropriate and suggested anticipatory guidance (health assessments):**

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

Signed: \_\_\_\_\_

Optometrist/Ophthalmologist

Date: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: ( ) \_\_\_\_\_

# Kentucky Eye Examination Form for School Entry

8/2000

KRS 156.160 (1) (g) requires proof of a vision examination by an optometrist or ophthalmologist. This evidence shall be submitted to the school no later than January 1 of the first year that a three (3), four (4), five (5) or six (6) year old child is enrolled in public school, public preschool, or Head Start program.

**PLEASE COMPLETE THE IDENTIFYING INFORMATION AND RECORDS**

**IDENTIFYING INFORMATION**

Student Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Parent or Guardian Name: \_\_\_\_\_

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

**CASE HISTORY**

Date of Exam: \_\_\_\_\_

Ocular History: Normal  or Positive for: \_\_\_\_\_

Medical History: Normal  or Positive for: \_\_\_\_\_

Drug Allergies: NKDA  or Allergic to: \_\_\_\_\_

Family Ocular and Medical History:  Amblyopia  Strabismus  Glaucoma  Diabetes  
Other: \_\_\_\_\_

Other Pertinent Information: \_\_\_\_\_

Refraction with cycloplegic? (please indicate one)  YES  NO

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

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

**Diagnosis:**  Normal  Myopia  Hyperopia  Astigmatism  Strabismus  Amblyopia

Other: \_\_\_\_\_

**Recommendations:**

1 Glasses prescribed:  YES  NO

2 \_\_\_\_\_

3 \_\_\_\_\_

**Age appropriate and suggested anticipatory guidance (health assessments):**

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

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
Optometrist/Ophthalmologist

Address: \_\_\_\_\_ Telephone: ( ) \_\_\_\_\_

Kentucky law, KRS 156.160(i), requires proof of a dental screening or examination by a dentist, dental hygienist, physician, registered nurse, advanced registered nurse practitioner, or physician assistant. This evidence shall be presented to the school no later than January 1 of the first year that a five (5) or six (6) year old is enrolled in public school.

<p><b>Student Name:</b> _____ Last _____ First _____ Middle _____</p> <p>Birth date: ____/____/____ Gender: <input type="checkbox"/> 0 Male <input type="checkbox"/> 1 Female</p> <p>Parent or Guardian: _____ Name _____ Relationship _____</p> <p>Address: _____ City: _____</p> <p>Phone Number: _____ School: _____</p> <p>Date of Exam/Screening ____/____/____</p>	<p>Test Type (check one)</p> <p><input type="checkbox"/> Screening</p> <p><input type="checkbox"/> Exam</p> <p><b>Screener's Name:</b> _____</p> <p>Screener's Address: _____</p> <p>Phone Number: _____ Screening Date: _____</p> <p>Screener's Signature: _____</p> <p><b>Professional affiliation: (Please check one)</b></p> <p><input type="checkbox"/> Dentist <input type="checkbox"/> Dental Hygienist</p> <p><input type="checkbox"/> Physician Assistant <input type="checkbox"/> LHD Registered Nurse with KIDS Smiles training</p> <p><input type="checkbox"/> APRN <input type="checkbox"/> Physician</p>
<p><b>Untreated Decay:</b> (Check one)</p> <p><input checked="" type="checkbox"/> 0 No untreated cavities</p> <p><input type="checkbox"/> 1 Untreated cavities</p>	<p><b>Treated Decay:</b> (Check one)</p> <p><input type="checkbox"/> 0 No treated cavities</p> <p><input type="checkbox"/> 1 Treated cavities</p>
<p><b>Pattern of Early Childhood Cavities:</b> (Check one)</p> <p><input type="checkbox"/> 0 No Early Childhood Cavities</p> <p><input type="checkbox"/> 1 Early Childhood Cavities Present</p>	<p><b>Treatment Urgency:</b> (Check one)</p> <p><input type="checkbox"/> 0 No obvious problem</p> <p><input type="checkbox"/> 1 Early dental care needed</p> <p><input type="checkbox"/> 2 Referral for Urgent Care</p> <p>NOTE: Comment required if marked.</p>
<p><b>Comments:</b></p>	

## Kentucky Dental Screening/Examination Form for School Entry

Kentucky law, KRS 156.160(i), requires proof of a dental screening or examination by a dentist, dental hygienist, physician, registered nurse, advanced registered nurse practitioner, or physician assistant. This evidence shall be presented to the school no later than January 1 of the first year that a five (5) or six (6) year old is enrolled in public school.

<p><b>Student Name:</b> _____ Last _____ First _____ Middle _____</p> <p>Birth date: ____/____/____ Gender: <input type="checkbox"/> 0 Male <input type="checkbox"/> 1 Female</p> <p>Parent or Guardian: _____ Name _____ Relationship _____</p> <p>Address: _____ City: _____</p> <p>Phone Number: _____ School: _____</p> <p>Date of Exam/Screening ____/____/____</p>	<p>Test Type (check one)</p> <p><input type="checkbox"/> Screening <input type="checkbox"/> Exam</p> <p><b>Screener's Name:</b> _____</p> <p>Screener's Address: _____</p> <p>Phone Number: _____ Screening Date: _____</p> <p>Screener's Signature: _____</p> <p><b>Professional affiliation: (Please check one)</b></p> <p><input type="checkbox"/> Dentist <input type="checkbox"/> Dental Hygienist</p> <p><input type="checkbox"/> Physician Assistant <input type="checkbox"/> LHD Registered Nurse with KIDS Smiles training</p> <p><input type="checkbox"/> APRN <input type="checkbox"/> Physician</p>
<p><b>Untreated Decay:</b> (Check one)</p> <p><input type="checkbox"/> 0 No untreated cavities</p> <p><input type="checkbox"/> 1 Untreated cavities</p>	<p><b>Treated Decay:</b> (Check one)</p> <p><input type="checkbox"/> 0 No treated cavities</p> <p><input type="checkbox"/> 1 Treated cavities</p>
<p><b>Pattern of Early Childhood Cavities:</b> (Check one)</p> <p><input type="checkbox"/> 0 No Early Childhood Cavities</p> <p><input type="checkbox"/> 1 Early Childhood Cavities Present</p>	<p><b>Treatment Urgency:</b> (Check one)</p> <p><input type="checkbox"/> 0 No obvious problem</p> <p><input type="checkbox"/> 1 Early dental care needed</p> <p><input type="checkbox"/> 2 Referral for Urgent Care</p> <p>NOTE: Comment required if marked.</p>
<p><b>Comments:</b></p>	







