PHYSICAL EXAMINATION FORM

For PRESCHOOL and KINDERGARTEN students only.

To be completed by the physician and faxed: ATTN School Nurse at 330-653-1234 (for Kindergarten) or 330-653-1235 (for Preschool).
Please provide a copy of child's immunization record.

STUDENT NAME:		**SEX:** ☐ Male ☐ Female	**BIRTHDATE:** / /
HEIGHT:	**WEIGHT:**	**BMI:**	**BP:**

SCREENING TESTS:

VISION
DATE PERFORMED: / /

DISTANCE ACUITY	☐ R	☐ L
MUSCLE BALANCE	☐ PASS	☐ FAIL
STEREOPSIS	☐ PASS	☐ FAIL
COLOR	☐ PASS	☐ FAIL
CHILD WEARS GLASSES	☐ YES	☐ NO
TESTED WITH GLASSES	☐ YES	☐ NO
REFERRAL MADE	☐ YES	☐ NO

HEARING
DATE PERFORMED: / /

PURE TONE
RIGHT ☐ PASS ☐ FAIL
LEFT ☐ PASS ☐ FAIL

CHILD WEARS HEARING AID ☐ YES ☐ NO

CHILD IS UNDER THE CARE OF A HEARING SPECIALIST ☐ YES ☐ NO

REFERRAL MADE ☐ YES ☐ NO

POSTURAL
DATE PERFORMED: / /

☐ NO ABNORMALITY NOTED
☐ NO SCREENING NOT DONE
☐ REFERRAL MADE

COMMENTS: _____

SPEECH/LANGUAGE

SPEECH ASSESSMENT COMPLETED	☐ YES	☐ NO
CHILD HAS NO DISCERNIBLE SPEECH PROBLEM	☐ YES	☐ NO
SPEECH EVALUATION RECOMMENDED	☐ YES	☐ NO

CHILD HAS POSSIBLE PROBLEM WITH: _____

LEAD POISONING (PRESCHOOL ONLY)

DATE _____ TYPE ☐ C ☐ V RESULTS _____ PG/DL

HBG/HCT (PRESCHOOL ONLY)

DATE _____ RESULTS _____

☐ NOT INDICATED

TUBERCULIN TEST

DATE _____ TYPE _____ RESULTS _____

HEALTH HISTORY (SERIOUS OR CHRONIC ILLNESSES, INJURIES, OR SURGERIES):

PHYSICAL EXAMINATION

DATE OF MOST RECENT EXAMINATION / /

☐ ESSENTIALLY NORMAL

☐ ABNORMALITIES AS FOLLOWS: _____

5/20/09
3/16/15

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CHILD IS ABLE TO FULLY PARTICIPATE IN:	CLASSROOM AND ACADEMIC ACTIVITIES ☐ YES ☐ NO PHYSICAL EDUCATION CLASSES ☐ YES ☐ NO CONTACT/COLLISION SPORTS ☐ YES ☐ NO	PLAYGROUND ACTIVITIES ☐ YES ☐ NO SWIMMING ☐ YES ☐ NO

SPECIFY ANY LIMITATIONS: _____

_____

LIST ANY PHYSICAL, DEVELOPMENTAL OR BEHAVIORAL ISSUES THAT MAY AFFECT THE CHILD'S EDUCATIONAL PROCESS:

_____

_____

ALLERGIES: _____

DIETARY RESTRICTIONS: _____

MEDICATIONS: _____

DIAGNOSIS (INCLUDE ANY HANDICAPPING CONDITION): _____

_____

COMMENTS: _____

_____

_____

_____

DENTAL EXAMINATION (IF PREFORMED BY PHYSICIAN) **DATE:** / /

☐ NO ABNORMALITY NOTED
☐ NO SCREENING NOT DONE
☐ REFERRAL MADE

COMMENTS: _____

_____

_____

HEALTH CARE PROVIDER SIGNATURE:		**DATE:** / /
HEALTH CARE PROVIDER PRINTED NAME:		**TELEPHONE:** ( ) --
ADDRESS:		
CITY:	**STATE:**	**ZIP CODE:**

5/20/09
3/16/15