

Physical Examination

| | | | |
|----------------|--------|--|----------------------|
| Student's name | | Sex <input type="checkbox"/> Male <input type="checkbox"/> Female | Date of birth / / |
| Height | Weight | BMI percentile | BP |

Screening Tests

| Vision | Hearing | Postural |
|---|---|---|
| Date performed / / | Date performed / / | Date performed / / |
| Distance Acuity <input type="checkbox"/> R <input type="checkbox"/> L Muscle Balance <input type="checkbox"/> Pass <input type="checkbox"/> Fail Stereopsis <input type="checkbox"/> Pass <input type="checkbox"/> Fail Color <input type="checkbox"/> Pass <input type="checkbox"/> Fail Child wears glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No Tested with glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No Referral made? <input type="checkbox"/> Yes <input type="checkbox"/> No | Pure Tone Right ear <input type="checkbox"/> Pass <input type="checkbox"/> Fail Left ear <input type="checkbox"/> Pass <input type="checkbox"/> Fail Child wears hearing aid? <input type="checkbox"/> Yes <input type="checkbox"/> No Child under the care of a hearing specialist <input type="checkbox"/> Yes <input type="checkbox"/> No Referral made? <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> No abnormality noted <input type="checkbox"/> Screening not done <input type="checkbox"/> Referral made Comments _____ _____ _____ |

| Speech/Language | Lead Poisoning |
|---|---|
| Speech assessment completed <input type="checkbox"/> Yes <input type="checkbox"/> No Child has no discernible speech problem <input type="checkbox"/> Yes <input type="checkbox"/> No Speech evaluation recommended <input type="checkbox"/> Yes <input type="checkbox"/> No Child has possible problem with _____ | <input type="checkbox"/> Date _____ Type <input type="checkbox"/> C <input type="checkbox"/> V Results _____ µg/dL <input type="checkbox"/> Date _____ Type <input type="checkbox"/> C <input type="checkbox"/> V Results _____ µg/dL Tuberculin Test Date _____ Type _____ Results _____ |

Health History (Serious or chronic illnesses/injuries/surgeries)

Physical Examination Date of most recent examination / /

Essentially normal Abnormalities as follows

Is this child able to participate fully in:

| | |
|--|---|
| Classroom and academic activities <input type="checkbox"/> Yes <input type="checkbox"/> No | Physical education classes <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Competition athletics <input type="checkbox"/> Yes <input type="checkbox"/> No | Contact and collision sports <input type="checkbox"/> Yes <input type="checkbox"/> No |

If limitations are advised, please specify

Does this child have any physical, developmental or behavioral issues that may affect his/her educational process?

| | | |
|---------------------------------|------------|-----------------|
| HealthCare Provider's signature | Print name | Phone () |
| Address | | Date / / |
| City | State | ZIP |