



# REPORT OF PHYSICAL EXAMINATION by HEALTHCARE PROVIDER

**\*\*\* Immunization record MUST be attached\*\*\***

Student Name:		Gender:		DOB:	
Height:		Weight:		BMI %:	
				BP:	
<b>Screening Tests</b>					
VISION		HEARING		POSTURAL	
Date performed:		Date performed:		Date performed:	
Distance Acuity <input type="checkbox"/> Pass <input type="checkbox"/> Fail Muscle Balance <input type="checkbox"/> Pass <input type="checkbox"/> Fail Stereopsis <input type="checkbox"/> Pass <input type="checkbox"/> Fail Color Vision <input type="checkbox"/> Pass <input type="checkbox"/> Fail Corrective lenses? <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 Hearing aid? <input type="checkbox"/> Pass <input type="checkbox"/> Fail 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 <input type="checkbox"/> Screening not done <input type="checkbox"/> Referral made Comments:	
Comments:		Comments:			
SPEECH/LANGUAGE			LEAD POISONING		
Speech assessment completed: <input type="checkbox"/> Yes <input type="checkbox"/> No Discernible speech problem: <input type="checkbox"/> Yes <input type="checkbox"/> No Speech evaluation recommended: <input type="checkbox"/> Yes <input type="checkbox"/> No Possible issue with:			Date:                      Type:                      Results:		
			TUBERCULIN TEST		
			Date:                      Type:                      Results:		
<b>Health History (serious or chronic illnesses/injuries/surgeries)</b>					
Please specify:					
<b>Physical Examination</b>					
<input type="checkbox"/> Essentially normal    OR <input type="checkbox"/> Abnormalities as follows:					
Is child able to participate fully in (write yes or no):					
Classroom activities: _____			Physical education classes: _____		
Competition athletics: _____			Contact and collision sports: _____		
If any limitations, please specify:					
Does the child have any physical, developmental, or behavioral issues that may affect his/her education?					
<b>Health Care Provider Information</b>					
Healthcare Printed Name Signature:			Phone Number:		
Office Name or Stamp:			Healthcare Provider Signature:		



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