

SECTION III - PHYSICAL EXAMINATION, INSPECTION, TESTS, AND MEASUREMENTS
EXAMINATION AND/OR INSPECTIONS

ESSENTIAL FINDINGS DEVIATING FROM NORMAL AND/OR RECOMMENDATIONS _____ _____ _____
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TESTS AND MEASUREMENTS

		Normal	Under Care	Referred			Normal	Under Care	Referred
Vision Tested? <input type="checkbox"/> Yes <input type="checkbox"/> No Date _____	<input type="checkbox"/> Visual Acuity <input type="checkbox"/> Ocular Muscle <input type="checkbox"/> Other				Urinalysis Done? <input type="checkbox"/> Yes <input type="checkbox"/> No Date _____	<input type="checkbox"/> Sugar <input type="checkbox"/> Albumin <input type="checkbox"/> Microscopic			
Hearing Tested? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Audiometer <input type="checkbox"/> Other				Blood Pressure Measured? <input type="checkbox"/> Yes <input type="checkbox"/> No Reading _____				
Hemoglobin/Hemotocrit Tested? <input type="checkbox"/> Yes <input type="checkbox"/> No					Height _____ Weight _____ Other: _____				

ESSENTIAL FINDING DEVIATING FROM NORMAL AND/OR RECOMMENDATIONS _____
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DOCTOR'S/NURSE'S SIGNATURE _____	DATE: _____
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Tuberculin Test (if given) Date _____ Type: _____ Negative Positive _____ mm.

SECTION IV - RECOMMENDATIONS

Is there any defect of vision, hearing, or other conditions for which the school could help by seating or other action? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain: _____

Should the student's activity be restricted because of any physical defect or illness? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, check below and explain degree of restriction: <input type="checkbox"/> Classroom <input type="checkbox"/> Playground <input type="checkbox"/> Gymnasium <input type="checkbox"/> Swimming Pool <input type="checkbox"/> Competitive Sports <input type="checkbox"/> Camp <input type="checkbox"/> Other

Examiner's Signature _____	Date _____	Examiner's Name (print or type) _____	Degree or License _____
Number & Street _____	City _____	Zip _____	Telephone _____

SECTION V – DENTAL EXAMINATION AND RECOMMENDATIONS (OPTIONAL)

I have examined _____ teeth and make the following recommendations as to treatment: _____ Child's Name
_____ _____
Dentist's Signature _____ Date _____

COMMENTS:

_____ _____ _____
