

ST. PETER SCHOOL PHYSICAL EXAMINATION FORM

Parents, we appreciate your cooperation in helping to improve and promote the School Health Program. Each student's health is important and greatly influences his educational progress.

The State of Ohio Commission on Education requires a medical examination upon or prior to entrance to **Kindergarten or first grade**. Additional examinations are required if any defect is suspected while the child is in school. Each student should be seen regularly by his physician for complete examinations throughout the school period. A dental examination is also recommended.

**THIS FORM IS TO BE COMPLETED BY YOUR PHYSICIAN
AT THE TIME OF YOUR CHILD'S EXAMINATION.
AND RETURNED TO THE SCHOOL OFFICE BEFORE THE FIRST DAY OF SCHOOL.**

IDENTIFYING INFORMATION:

NAME OF STUDENT _____ **DATE OF BIRTH** _____

FAMILY PHYSICIAN _____ **DENTIST** _____

TEST	DATE	RESULTS	TEST	DATE	RESULTS	
PRESENT AGE			VISION			
HEIGHT (No shoes, to nearest 1/8 inch)			Acuity, R/L			
			Re-Screening			
WEIGHT (Light clothing to nearest 1/4 pound)			Strabismus			
			Comments			
BLOOD PRESSURE			OTHER TESTS (If indicated)			
HEMATOCRIT OR HEMOGLOBIN			Sickle Cell			
			Lead			
HEARING (Type of Test) Results R/L Re-Screening			Ova and Parasites			
			Urinalysis			
			Other			
SPEECH		Normal / Abnormal				
IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
DPT						
HEP-B						
HIB						
MMR						
POLIO						
TB						
VARICELLA						

Please check those items that revealed any abnormalities during examination:

- | | | | |
|--------------------------|-------------------|-----------------|-----------------------------------|
| _____ General Appearance | _____ Eyes | _____ Lungs | _____ Skeletal System |
| _____ Skin | _____ Ears | _____ Abdomen | _____ Neuro Muscular |
| _____ Lymph Nodes | _____ Nose/Throat | _____ Genitalia | _____ Teeth, Gums, Tongue, Palate |
| _____ Heart | | | |

Describe fully, any abnormalities:

Based upon the medical history and physical condition at the time of this examination, he/she is free from communicable diseases, including Tuberculosis; and has received immunizations required by statute for admission to school under Section 3313.671 of the Revised Code, or has had the immunizations required by the State Department of Health for infants and toddler.

PHYSICIAN SIGNATURE: _____ **DATE:** _____

DENTIST:

At this time, child has no apparent dental defects _____

Child is under regular dental care _____

Appointments have been made for correction of defects _____

DENTIST SIGNATURE: _____ **DATE:** _____