

To be completed by Physician

North Olmsted City Schools

## School Entrance Physical Examination

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_

### Immunization Information

*\*\*Please enter entire date including month, day and year.*

**DTaP/DTP:** 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_ 5. \_\_\_\_\_  
**Td:** 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_ 5. \_\_\_\_\_  
**Polio** 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_ 5. \_\_\_\_\_  
**HIB:** 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_ 5. \_\_\_\_\_  
**Hepatitis B:** 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_ 5. \_\_\_\_\_  
**Hepatitis A:** 1. \_\_\_\_\_ 2. \_\_\_\_\_  
**MMR:** 1. \_\_\_\_\_ 2. \_\_\_\_\_  
**Varicella:** 1. \_\_\_\_\_ 2. \_\_\_\_\_  
**Other:** \_\_\_\_\_

Exempt from Immunizations	Please circle one	
Religious Conviction	yes	no
Health Concern	yes	no
Other:		

### Physical Examination

Examination Date: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BMI: \_\_\_\_\_

Normal \_\_\_\_\_ Abnormal \_\_\_\_\_ Development: Normal \_\_\_\_\_ Abnormal \_\_\_\_\_

Remarks and recommendations concerning abnormal findings: \_\_\_\_\_

Restrictions: \_\_\_\_\_

Tests (at discretion of physician):

Lead \_\_\_\_\_ Hematocrit: \_\_\_\_\_ Urinalysis: \_\_\_\_\_ Hemoglobin \_\_\_\_\_ Other \_\_\_\_\_

Tuberculin test: Most recent Date \_\_\_\_\_ Type \_\_\_\_\_ Results: Positive \_\_\_\_\_ Negative \_\_\_\_\_

**Chronic Medical Concerns:** Asthma \_\_\_\_\_ Seizure Disorder \_\_\_\_\_ ADD/ADHD \_\_\_\_\_ Diabetes \_\_\_\_\_

Other \_\_\_\_\_ Elaborate on any condition: \_\_\_\_\_

**Medications:** Name/dose/frequency/reason: \_\_\_\_\_

*(\*\*Please Note: a "Medication Administration" form must be completed for any prescribed or OTC medication that is to be given at school)*

**Hearing:** Type of test \_\_\_\_\_ Results: \_\_\_\_\_ Comments: \_\_\_\_\_

**Vision:** Acuity Right - 20/\_\_\_\_ Left - 20/\_\_\_\_ Strabismus: YES NO Comments: \_\_\_\_\_

Was child referred for any reason? Explain \_\_\_\_\_

Based on examination consistent with EPSDT/Headstart/AAP guidelines. I certify this child to be in suitable condition for enrollment in school.

Physician Name (print): \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_