

SECTION III -- PHYSICAL EXAMINATION, INSPECTION, TESTS, AND MEASUREMENTS

EXAMINATIONS AND/OR INSPECTIONS

ESSENTIAL FINDINGS DEVIATING FROM NORMAL AND/OR RECOMMENDATIONS

TESTS AND MEASUREMENTS

		Normal	Under Care	Referred			Normal	Under Care	Referred
Vision Tested? <input type="checkbox"/> Visual Activity <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Ocular Muscle Date _____ <input type="checkbox"/> Other _____					Urinalysis Done? <input type="checkbox"/> Sugar <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Albumin Date _____ <input type="checkbox"/> Microscopic				
Hearing Tested? <input type="checkbox"/> Audiometer <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other _____ Date _____					Blood Pressure Measured? <input type="checkbox"/> Yes <input type="checkbox"/> No Reading _____				
Hemoglobin/Hematocrit Tested? <input type="checkbox"/> Yes <input type="checkbox"/> No					Height _____ Weight _____ Other:				
Blood Lead Level Tested? <input type="checkbox"/> Yes <input type="checkbox"/> No Date _____ Reading _____					Blood Lead level recommended for all children age six and under				

ESSENTIAL FINDINGS DEVIATING FROM NORMAL AND/OR RECOMMENDATIONS

Tuberculin Test (if given) Date _____ Type _____ Negative Positive _____ mm.

SECTION IV -- RECOMMENDATIONS

Is there any defect of vision, hearing, or other condition for which the school could help by seating or other action? Yes No
 If yes, please explain:

Should the student's activity be restricted because of any physical defect or illness? Yes No If yes, check below and explain degree of restriction:

Classroom Playground Gymnasium Swimming Pool Competitive Sports Camp 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 for treatment:

Child's Name _____

Dentist's Signature _____ Date _____

COMMENTS
