

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"/> 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 Date _____	<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: _____				

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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 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 to treatment: _____
Child's Name

_____ Dentist's Signature _____ Date _____

COMMENTS:
