6451 Center Street
Mentor, OH 44060

PHYSICAL EXAM FOR PRE-SCHOOL ENROLLMENT

STUDENT: ______________________ BIRTH DATE: ______________

ADDRESS: ______________________ TELEPHONE: ______________

FINDINGS:

Weight: ______________

Height: ______________

General Appearance: ______________

Skin: ______________

Posture: ______________

Eyes: ______________

Ears: ______________

Nose: ______________

Throat (tonsils): ______________

Mouth: ______________

Neck: ______________

Heart: ______________

Blood Pressure: ______________

Lungs: ______________

Abdomen: ______________

Genitalia: ______________

Hernia: ______________

Extremities: ______________

Nervous System: ______________

Urinalysis: ______________

Known Allergies (bees, food, environment, medication):

____

____

Physical defect or condition (orthopedic, cardiac, respiratory, etc.) which may limit participation at school activities:

____

Vision screening results: Right Eye Left Eye

Eye condition or defect in vision: ______________

Ear condition or defect in hearing: ______________

Hearing screening results: Right Ear Left Ear

Indicate conditions which may result in a classroom emergency (e.g., asthma, epilepsy, diabetes, heart condition, fainting spells)

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Date of DPT Booster: ______________ Date of MMR Booster: ______________

Date of Polio Booster: ______________ Dates of Hepatitis B Series: ______________

Recommendations for Physical Education:

a. Full program ______________

b. Restricted: ______________

State law requires these immunizations:
4 DPT(last DPT to be given after age 4)
3 Poliomyelitis (last dose to be given after age 4)
1 MMR (on or after the first birthday)
3 Hepatitis B Vaccine Series
3 Hib
1 Varicella

PHYSICIAN'S SIGNATURE: ______________________ **DATE:** ______________