



**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 Activity <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/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 \_\_\_\_\_ Child's Name \_\_\_\_\_ teeth and make the following recommendations as for treatment:

---



---

Dentist's Signature \_\_\_\_\_ Date \_\_\_\_\_

**COMMENTS**

---



---



---