

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

EXAMINATIONS AND/OR INSPECTIONS

ESSENTIAL FINDINGS DEVIATING FROM NORMAL AND/OR RECOMMENDATIONS

TESTS AND MEASUREMENTS

	Within Normal Limits	Under Care	Referred		Within Normal Limits	Under Care	Referred
Vision Tested? <input type="checkbox"/> Visual Activity <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Muscle Imbalance Date _____ <input type="checkbox"/> Other _____ <small>(Specify)</small>				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 _____ <small>(Specify)</small> Date _____				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:			
Blood Lead Level Tested? <input type="checkbox"/> Yes <input type="checkbox"/> No Date _____ Result _____				Blood Lead level recommended for all children enrolled in Medicaid must be tested at one and two years of age, or once between three and six years of age if not previously tested. All children under age six living in high risk areas should be tested at the same intervals as noted above.			

ESSENTIAL FINDINGS DEVIATING FROM NORMAL AND/OR RECOMMENDATIONS

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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:

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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

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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
