

## Pickerington Schools

# Physical Exam Form

For new students enrolling into kindergarten or grade 1. Please have your child's health care provider complete this form and return it to your child's assigned school building. **Your child will not be cleared to attend school until this form has been signed and returned to the school on or before August 1.**

|                 |         |      |             |            |
|-----------------|---------|------|-------------|------------|
| Student's name: |         | Sex: | Birth date: | Exam date: |
| Height:         | Weight: | BMI: | BP:         |            |

### Vision, Hearing, and Speech-Language

|                      |                               |                               |                                         |                               |                               |
|----------------------|-------------------------------|-------------------------------|-----------------------------------------|-------------------------------|-------------------------------|
| Date of vision test: |                               |                               | Date of hearing test:                   |                               |                               |
| Distance acuity      | <input type="checkbox"/> R    | <input type="checkbox"/> L    | Pure tone: right ear                    | <input type="checkbox"/> Pass | <input type="checkbox"/> Fail |
| Muscle Balance       | <input type="checkbox"/> Pass | <input type="checkbox"/> Fail | Pure tone: left ear                     | <input type="checkbox"/> Pass | <input type="checkbox"/> Fail |
| Stereopsis           | <input type="checkbox"/> Pass | <input type="checkbox"/> Fail | Child wears hearing aid?                | <input type="checkbox"/> Yes  | <input type="checkbox"/> No   |
| Color                | <input type="checkbox"/> Pass | <input type="checkbox"/> Fail | Child under care of hearing specialist? | <input type="checkbox"/> Yes  | <input type="checkbox"/> No   |
| Child wears glasses? | <input type="checkbox"/> Yes  | <input type="checkbox"/> No   | Referral made?                          | <input type="checkbox"/> Yes  | <input type="checkbox"/> No   |
| Tested with glasses? | <input type="checkbox"/> Yes  | <input type="checkbox"/> No   |                                         |                               |                               |
| Referral made?       | <input type="checkbox"/> Yes  | <input type="checkbox"/> No   |                                         |                               |                               |

  

|                                         |                                                          |                                               |  |
|-----------------------------------------|----------------------------------------------------------|-----------------------------------------------|--|
| Date of speech-language testing:        |                                                          | Speech assessment completed:      Yes      No |  |
| Child has no discernible speech problem | <input type="checkbox"/> Yes <input type="checkbox"/> No | Child has possible problem with:              |  |
| Speech evaluation recommended           | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                               |  |

**Please complete page 2. All pages must be completed before this form is submitted to your child's school**

|                 |             |
|-----------------|-------------|
| Student's name: | Birth date: |
|-----------------|-------------|

Health History

Illness, Injury, Surgery: Please list any serious or chronic illnesses, injuries, or surgeries.

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Current Medications: Prescribed, Over the counter, Supplements.

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Allergies: Please note any allergies and recommended treatment.

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Physical Exam: Please indicate the date of the child's most recent physical exam.

Results:

- ☐ Essentially normal
- ☐ Abnormalities as follows:

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Is this child able to fully participate in:  
Classroom and academic activities      Yes      No      Physical Education classes:      Yes      No

If limitations are advised, please specify:

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Does this child have any physical, developmental, or behavioral issues that may affect their educational process?

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**Immunization Record: Please attach your child's immunization record. Without proof of the required Ohio Department of Health required immunizations or valid exemption, your child will not be cleared to participate in school.**

Health Care Provider's signature: \_\_\_\_\_ Print Name: \_\_\_\_\_

Date: \_\_\_\_\_ Telephone number: \_\_\_\_\_ Address: \_\_\_\_\_