



SCHOOL ENTRANCE PHYSICAL EXAMINATION
(TO BE COMPLETED BY PHYSICIAN)

Name: _____ Date of Birth: _____ Grade _____

Immunization Information

Please complete using the date/month/year

DTaP:	1. _____	2. _____	3. _____	4. _____	5. _____
Td:	1. _____	2. _____	3. _____	4. _____	5. _____
IPV/OPV:	1. _____	2. _____	3. _____	4. _____	5. _____
HIB:	1. _____	2. _____	3. _____	4. _____	
Hepatitis B:	1. _____	2. _____	3. _____	4. _____	
MMR:	1. _____	2. _____	Hepatitis A:	1. _____	2. _____
Varicella:	1. _____	2. _____	Meningococcal	1. _____	2. _____
Pneumococcal:	1. _____	2. _____	3. _____	4. _____	
Influenza:	_____		Other:	_____	

Height: _____ Weight: _____

Exam Date _____ Normal ___ Abnormal findings _____

MANDATORY SCREENINGS FOR PRESCHOOLERS REQUIRED BY THE OHIO DEPARTMENT OF EDUCATION

General Dental Health _____

Hearing: Right: _____ Left: _____

Vision: Acuity: Right 20/ _____ Left 20/ _____

Strabismus: Yes ___ No ___ Comments _____

Lead: _____ Hematocrit: _____

Tuberculin test (most recent): Date _____ Results: Positive _____ Negative _____

Chronic Health Concerns: Asthma: _____ Seizure Disorder: _____ ADD/ADHD: _____
 Diabetes: _____ Speech therapy: _____ Ear Infections: _____

Other: _____

Was the child referred to any specialists? _____

Restrictions: _____

Medications: Name/dosage/frequency: _____

Please complete the school's forms for medication administration if it is necessary for the child to receive prescription or over-the-counter medication in school

Physician name (print): _____ Phone: _____

Address: _____ City/State/Zip: _____

Based on examination consistent with EPSDT/Headstart/AAP guidelines, I certify this child to be in suitable condition for enrollment in school.

Physician signature: _____ Date: _____