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._____
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:**_____

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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:** _____