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	☐ R	☐ L	Pure tone: right ear	☐ Pass	☐ Fail
Muscle Balance	☐ Pass	☐ Fail	Pure tone: left ear	☐ Pass	☐ Fail
Stereopsis	☐ Pass	☐ Fail	Child wears hearing aid?	☐ Yes	☐ No
Color	☐ Pass	☐ Fail	Child under care of hearing specialist?	☐ Yes	☐ No
Child wears glasses?	☐ Yes	☐ No	Referral made?	☐ Yes	☐ No
Tested with glasses?	☐ Yes	☐ No			
Referral made?	☐ Yes	☐ No			

Date of speech-language testing:			Speech assessment completed: Yes No
Child has no discernible speech problem	☐ Yes	☐ No	Child has possible problem with:
Speech evaluation recommended	☐ Yes	☐ 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.

Current Medications: Prescribed, Over the counter, Supplements.

Allergies: Please note any allergies and recommended treatment.

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

Results:

- ☐ Essentially normal
- ☐ Abnormalities as follows:

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:

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

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:_____