



**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**
