Preschool Physical Exam Record

Marion City Schools

Child’s name:______________________  Male:___  Female:___  Age:___

Parent’s name:____________________________  Birthdate:_____________

Address:_________________________________________________________________

Objective Date

Height:____ (   )%  Weight:____ (   )%  BP:________

Screening Tests:

Vision:

Distance Acuity: Right:_______  Left:________

Child wears glasses? Yes____  No____  Tested with glasses? Yes____  No____

Specify test/equipment________________________________________________

Hearing:

Pure Tone Testing:

Right Ear: Pass____  Fail____  Not Done____

Left Ear: Pass____  Fail____  Not Done____

Child wears hearing aid? Yes____  No____  Tested with hearing aid?  Yes____  No____

Other Test
(Specify)_____________________________________________________________

Speech Assessment

_____ Child has no discernible speech problems

_____ Child may have problems with:  ___ Articulation  ___ Rhythm  ___ Voice  ___ Language
Speech
Evaluation is recommended ____ Yes ____ No

Laboratory Test

____ Lead (Required per Ohio Department of Education to be completed!!!) Result:_____

**If not completed today, please specify date & results of last Lead screening__________

____ Hemoglobin/Hematocrit Results:_________________

____ Other (Specify)

____________________________________________________________

Physical Examination

____ This child is essentially within normal limits.

____ This child is not within normal limits: (Please explain)________________

____________________________________________________________

Communicable Diseases:

The child is free of communicable diseases. ____ Yes ____ No

Does this child have any physical, developmental, or behavioral problems?

____ Yes ____ No

Activities and Limitations:

Can this child participate fully in the following activities?

Classroom and academic activities: ____ Yes ____ No

Physical education classes: ____ Yes ____ No

Specify any limitations:_________________________________________________________
Is this child on any medications: ____ Yes ____ No

If yes, please list:

____________________________________________________________________________

Immunizations

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Physician’s Name (please print):

____________________________________________________________________________

Physician’s Signature

Date __________

Address:

____________________________________________________________________________

Physician’s Please Note: Preschoolers must have this completed physical exam record signed by a physician to attend Marion City Preschools. This includes but is not limited to vision, hearing, height, weight, lead, and hematocrit screenings. Please note that a lead test is required for our records per Ohio Department of Education.