



**SECTION III -- PHYSICAL EXAMINATION, INSPECTION, TESTS, AND MEASUREMENTS**  
**EXAMINATIONS AND/OR INSPECTIONS**

ESSENTIAL FINDINGS DEVIATING FROM NORMAL AND/OR RECOMMENDATIONS

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**TESTS AND MEASUREMENTS**

		Normal	Under Care	Referred			Normal	Under Care	Referred
Vision Tested? <input type="checkbox"/> Yes <input type="checkbox"/> No Date _____	<input type="checkbox"/> Visual Acuity <input type="checkbox"/> Ocular Muscle <input type="checkbox"/> Other _____				Urinalysis Done? <input type="checkbox"/> Yes <input type="checkbox"/> No Date _____	<input type="checkbox"/> Sugar <input type="checkbox"/> Albumin <input type="checkbox"/> Microscopic			
Hearing Tested? <input type="checkbox"/> Yes <input type="checkbox"/> No Date _____	<input type="checkbox"/> Audiometer <input type="checkbox"/> Other _____				Blood Pressure Measured? <input type="checkbox"/> Yes <input type="checkbox"/> No Reading _____				
Hemoglobin/Hemocrit 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 _____ Reading _____					Blood Lead level recommended for all children age six and under				

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 \_\_\_\_\_

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\_\_\_\_\_  
 Dentist's Signature \_\_\_\_\_ Date \_\_\_\_\_

**COMMENTS**

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