

**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**

		Within Normal Limits	Under Care	Referred			Within Normal Limits	Under Care	Referred
Vision Tested? <input type="checkbox"/> Yes <input type="checkbox"/> No Date _____	<input type="checkbox"/> Visual Activity <input type="checkbox"/> Muscle Imbalance <input type="checkbox"/> Other _____ (Specify)				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 _____ (Specify)				Blood Pressure Measured? <input type="checkbox"/> Yes <input type="checkbox"/> No Reading _____				
Hemoglobin/Hematocrit 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 \_\_\_\_\_

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\_\_\_\_\_

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\_\_\_\_\_

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

**COMMENTS**

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