Pre-K and Kindergarten ONLY
Ohio Department of Health • School and Adolescent Health
Physical Examination
(to be completed by student's physician at the child's 5-year-old physical)

Student's Name	Sex ☐ Male ☐ Female	Date of Birth / /	
Height	Weight	BMI percentile	BP

Screening Tests

Vision			**Hearing**			**Postural**
Date Performed / /			Date Performed / /			Date Performed / /
Distance Acuity	☐ R	☐ L	Pure Tone			☐ No abnormality noted
Muscle Balance	☐ Pass	☐ Fail	Right Ear	☐ Pass	☐ Fail	☐ Screening not done
Stereopsis	☐ Pass	☐ Fail	Left Ear	☐ Pass	☐ Fail	☐ Referral made
Color	☐ Pass	☐ Fail	Child wears hearing aid?	☐ Yes	☐ No	Comments ___________________________
Child wears glasses?	☐ Yes	☐ No	Child under the care of a			
Tested with glasses?	☐ Yes	☐ No	hearing specialist?	☐ Yes	☐ No	___________________________________
Referral Made?	☐ Yes	☐ No	Referral mode?	☐ Yes	☐ No	
	☐ Yes	☐ No				

Speech/Language | **Lead Poisoning**

Speech/Language			Lead Poisoning
Speech assessment completed	☐ Yes	☐ No	☐ Date____________ Type ☐ C ☐ V Results __________ ug/dl
Child has no discernible speech problem	☐ Yes	☐ No	
Speech evaluation recommended	☐ Yes	☐ No	☐ Date ____________ Type ☐ C ☐ V Results __________ ug/dl
Child has possible problem with: ______________________________			**Tuberculin Test** Date __________ Type __________ Results __________

Health History (Serious or Chronic illness/injuries/surgeries)

Physical Examination Date of most recent examination / /

☐ Essentially normal ☐ Abnormalities as follows

Is this child able to participate fully in:

Classroom and academic activities	☐ Yes	☐ No	Physical Education classes	☐ Yes	☐ No
Competition athletics	☐ Yes	☐ No	Contact and collision sports	☐ Yes	☐ No

If limitation are advised, please specify

Does this child have any physical, developmental or behavioral issues that may affect his/her education process?

HealthCare Provider's Signature	Print Name	Phone ( )
Address		Date / /
City	State	Zip