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Health Commissioner

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Public Health
Prevent. Promote. Protect.
Northeast Ohio Public Health Partnership

PRE-SCHOOL ENTRANCE PHYSICAL EXAMINATION

Child's Name: ______________________ Date of Birth: __________ Grade: ________

Mandatory screenings required by the Ohio Department of Education, effective 2008-2009 school year:

Hearing: **Right:** ____________ **Left:** ____________

Vision: **Acuity: Right 20/**______ **Left 20/**______ **Stereopsis:** ______________________

Height: __________ **Weight:** __________ **Lead:** ______________ **Hematocrit:** ____________

General Dental Health: ____

Immunization Information

Please complete using the date/month/year

DTaP:	1.________	2.________	3.________	4.________	5.________
Td:	1.________	2.________			
IPV/OPV:	1.________	2.________	3.________	4.________	5.________
HIB:	1.________	2.________	3.________	4.________	
Hepatitis B:	1.________	2.________	3.________		
MMR:	1.________	2.________	Hepatitis A:	1.________	2.________
Varivax:	1.________	2.________	Other: ______________		

Chronic Health Concerns: Asthma: ______ Seizure Disorder: ______ ADD/ADHD: ________

Diabetes: ____________________ Speech therapy: __________ Ear infections ____________
Other: ____

Was the child referred to any specialists? ____

Restrictions: ____

Medications: ____

____

Please complete the school's forms for medication administration if it is necessary for the child to receive prescription or over-the-counter medication in school.

Physician name (Print): ____________________________ Phone: ________________

Address: ________________________________ City/State/Zip: ________________

Based on examination consistent with EPSDT/Headstart/AAP guidelines, I certify this child to be in suitable condition for enrollment in school.

Physician signature: ________________________________ Date: __________