School Entry Physical Exam Form

Student Name **Date of Exam**

Screenings

Vision Screening		Nursing Staff	Hearing Screening					
☐ No re-check needed ☐ Needs re-checked in office		**Nursing Staff:** An initial screening was performed at kindergarten registration. If either section is checked a repeat screening is required during the student's physical exam.	☐ No re-check needed ☐ Needs re-checked in office					
Right Eye:	/		Left:			Right:		
Left Eye:	/		Pass			Pass		
Stereopsis	Pass		Fail			Fail		
	Fail		1000	3000	4000	1000	3000	4000
☐ Referral made to:								

Vital Signs

Height	Weight	Temperature	Pulse	Respirations

Physical Exam

System	Normal	Describe Abnormal
Neurologic		
HEENT		
Dental		
Lymphatic		
Heart		
Lungs		
Abdomen		
Orthopedic		
Skin		
Other:		

Critical Health Assessment

Asthma	☐ Yes ☐ No	Treatment:
Anaphylaxis	☐ Yes ☐ No	Treatment:
Diabetes	☐ Yes ☐ No	Treatment:
Seizures	☐ Yes ☐ No	Treatment:

Please check the appropriate box if an immunization was given during the office visit	DTaP	Polio	Hep B	Varicella	MMR	MEV

This student is medically able to attend school

Physician's Signature: Date:

NAME ______________________________ BIRTH DATE ______________ SCHOOL ______________

OHIO SCHOOL HEALTH RECORD
DENTIST'S REPORT

The following services have been performed:

________ Examinations

________ Diagnosis

________ Radiographs

________ Oral prophylaxis

________ Prescription for fluoride supplements

________ Topical application of fluoride

The following oral hygiene instruction was provided:

________ Tooth brushing

________ Flossing

________ Diet counseling reflecting relation of diet to dental health

________ Home/school use of fluoride mouth rinse

The following statements are applicable:

________ All necessary services have been performed

________ No restorative services are required at this time

________ Further treatment is indicated

________ Further appointments have been arranged

COMMENTS: ____

____

____

PLEASE PRINT OR STAMP

Dentist's Name: ____

Address ___________________________ City ______________ State _____ Zip _________

Phone (   ) ________________________________

Dentist's Signature ____________________________________ Date Signed ____________________

This form should be turned in at the school office no later than the second week of classes.