

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

ESSENTIAL FINDINGS DEVIATING FROM NORMAL AND/OR RECOMMENDATIONS

**TESTS AND MEASUREMENTS**

	Normal	Under Care	Referred		Normal	Under Care	Referred
Vision Tested? <input type="checkbox"/> Visual Acuity <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Ocular Muscle Date _____ <input type="checkbox"/> Other _____				Urinalysis Done? <input type="checkbox"/> Sugar <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Albumin Date _____ <input type="checkbox"/> Microscopic			
Hearing Tested? <input type="checkbox"/> Audiometer <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other _____ Date _____				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: _____			

ESSENTIAL FINDINGS DEVIATING FROM NORMAL AND/OR RECOMMENDATIONS

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


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

Dentist's Signature	Date

**COMMENTS**
