CLEVELAND METROPOLITAN SCHOOL DISTRICT

PHYSICAL EXAMINATION REPORT

Child's Name	**DOB**	**Sex** ☐ **M** ☐ **F**	**Age**	**Date of Exam**

Significant Medical History (include chronic illness, injuries, and hospitalizations):

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Any medical restrictions? What are they? (Please explain reason why?)

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Speech Development: Normal ☐ Delayed ☐ Referred ☐ (SLP? ☐): ______________________

Motor Development: Normal ☐ Delayed ☐ Referred ☐ (OT/PT? ☐): ______________________

Allergies: (Epi-Pen needed?)

Does child wear glasses? ☐ **Y** ☐ **N**	**Does child wear hearing aids?** ☐ **Y** ☐ **N**
Does child require special equipment? ☐ **Y** ☐ **N**	**Specify:**

Tests and Measurements:

Height	**Weight**	**Pulse**	**BP** ______/______
Vision Screen Date:	OD 20/ OS 20/	**Hearing Test** Date:	R L
Lead Testing History of elevated lead level? ☐ **Y** ☐ **N**	**Highest lead level** Date: Result: _______mcg/dL	**Treatment**	**Most Recent Lead Test** Date: Result: _______mcg/dL
Glucose Screening Date: Result:	**HCT/HGB -** Date: Result:	**Sickle Cell Test** Date:	**Result**

General Physical Exam: (Please explain abnormal findings)

	Normal	Abnormal		Normal	Abnormal
General appearance	☐	☐	Lungs	☐	☐
Nutrition	☐	☐	Abd	☐	☐
Skin	☐	☐	GI	☐	☐
Head	☐	☐	Genitalia	☐	☐
Eyes	☐	☐	GU	☐	☐
ENT	☐	☐	Neu	☐	☐
Teeth	☐	☐	NM	☐	☐
Neck	☐	☐	Spine/Scoliosis	☐	☐
Thyroid	☐	☐	Lymph nodes	☐	☐
Heart	☐	☐	Extremities	☐	☐

Explanation of abnormal findings:

______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

******Please continue to second page******

General Neurological Exam:

	Normal	Abnormal		Normal	Abnormal
Gait	□	□	Muscle Tone	□	□
Station	□	□	Reflexes	□	□
Muscle Strength	□	□	Cranial Nerves	□	□

Gross Motor Coordination: ____

Fine Motor Coordination: ____

Sensory: ____

Mental Health/Behavioral Health:

Hyperactive	□	Disturbed sleep pattern	□
Withdrawn	□	Aggression	□
Short attention span	□	Other (please describe)	□

Notes: ____

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Current Medications/Treatment Regimens (i.e. Tube feed, Suction, Glucose testing):

____________________ ____________________

____________________ ____________________

____________________ ____________________

____________________ ____________________

Medical Recommendations/Referrals:

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I certify that the above-named student has had a complete physical examination:

Physician/Examiner's Name: (Print) ______________________________

Physician/Examiner's Signature: ______________________ **Date:**________

Address: ______________________

____

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Telephone: ______________________

Fax: ______________________

Office Stamp:

*******Please attach a current immunization record *******

PLEASE RETURN TO SCHOOL NURSE AT YOUR CHILD'S SCHOOL. THANK YOU!