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):

_____

_____

_____

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

_____

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******

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PHYSICAL EXAMINATION REPORT

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Withdrawn	☐	Aggression	☐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: _____

_____

_____

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

_____ _____

_____ _____

_____ _____

_____ _____

Medical Recommendations/Referrals:

_____

_____

_____

_____

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

Physician/Examiner's Name: (Print) _____

Physician/Examiner's Signature: _____ **Date:**_____

Address: _____

_____

_____

Telephone: _____

Fax: _____

Office Stamp:

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

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

Immunization Record for _____(child's name)

	Vaccine	(mo/day/yr)
Hepatitis B (e.g., HepB, Hib-HepB, DTap-HepB-IBV) Give IM		
Diphtheria, Tetanus, Pertussis (e.g., DTap, DTap/Hib, DTap-HepB-IPV, DT, DTap-IPV/Hib, Tdap, Dtap-IPV, Td) Give IM		
Haemophilus Influenzae Type b (e.g., Hib, Hib-HepB, DTap,/Hib) Give IM		
Polio (e.g., IPV, DTap-HepB-IPV, DTap-IPV/Hib, DTap-IPV) Give IPV SC or IM. Give all others IM		
Vaccine	**Type of Vaccine**	**Date given (mo/day/yr)**
Measles, Mumps, Rubella (e.g., MMR, MMRV) Give SC		
Varicella (e.g. VAR, MMRV) Give SC		
Hepatitis A (Hep A) Give IM		
Meningcoccal (e.g., MCV4, MPSV4) Give MCV4 IM and MPSV4 SC		