"We Inspire and Empower Learners"

NORTH ROYALTON CITY SCHOOLS

School Entrance Physical Examination
Kindergarten & Newly Enrolled 1st Grade Students

Name: _____ Birthdate: _____

School: _____ Grade: _____

Immunization Information

Please complete the entire date including ***month, day and year*** (or attach a copy of the immunization record):

DTP/DtaP 1._____ 2._____ 3._____ 4._____ 5._____

Td: 1._____ 2._____

OPV/IPV 1._____ 2._____ 3._____ 4._____ 5._____

HIB: 1._____ 2._____ 3._____ 4._____ 5._____

Hepatitis B: 1._____ 2._____ 3._____

MMR: 1._____ 2._____ Hepatitis A: 1._____ 2._____

Varicella: 1._____ 2._____ Prevnar (PCV): 1._____2._____3._____

Annual Influenza vaccine:_____

Examination

Height: _____ Weight: _____ Blood Pressure: _____ /_____

Examination: Date: _____ Normal _____ Abnormal _____

Restrictions: _____ Development: Normal _____ Abnormal _____

Chronic Health Concerns: Asthma_____ Seizure Disorder_____ ADD/ADHD_____ Diabetes_____
Other: _____

Medications:
Name of medication/dosage/frequency:_____
Reason for medication:_____

Please complete form for medication administration if it is necessary for the child to receive prescription or OTC medication in school.

Was child referred to a specialist for any reason? Yes _____ No _____
*Reason: _____

Special Tests (All screenings are recommended by the Ohio Department of Health)

Urinalysis _____ Hemoglobin _____ Sickle Cell _____
Hematocrit_____Lead_____
Tuberculin test: (most recent) Date:_____ Type:_____ Results: Positive____Negative____
Other_____
Hearing: Type of test_____ Results_____ Comments_____
Vision: Acuity: Right – 20/_____ Left – 20/_____
Strabismus: Yes____No____ Comments:_____
Dental Screening (by Pediatrician or Dentist): Normal_____ Abnormal_____ Referral_____

Was child referred to a specialist for any of the above screenings? Yes____No____*Reason:_____

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:_____

* We are required to document follow-up information on any referrals made for the child.