NORWOOD ESCUELAS DE LA CIUDAD

Ohio Escuela Historia Escuela: ______________

EVALUACIÓN DE ESTUDIANTE POR MÉDICO Enrolled: ______________

Este formulario debe ser completado por el médico de su hijo.

Name: ____________________________ Gender: _____ Age:_____ DOB: _________

Ethnicity: ☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian American ☐ Other

Objective Data:

Height_____________ Weight: ___________ B.P.:______________

IMMUNIZATION Required for school entry						
TYPE	DATE: MO/DAY/YEAR					
DtaP, DPT or DT						5th dose required if 4th dose given before 4th b-day for **Kindergarten**
DT/Td					**Grades 1-12*:** 3-4 doses of DtaP, DTP, DT or Td or any combination **Grade 7-8: 1 dose of Tdap or Td prior to entry into 7th grade**	
POLIO					**K-1** students must have 3 or 4 doses of IPV, final dose on or after 4th bday; 4 doses if a combination of OPV/IPV. **Grades 2-12** 4 doses if combination IPV/OPV. 4 doses if all IPV/OPV & if the final dose was given before 4th birthday	
MMR					**KG-12**: 2 doses required for 2011-12	
HEPATITIS B					**K-12**: 3 doses required for 2011-12	
VARICELLA					**K-1** must have 2 doses for 2011-12 **Gr. 2-5** must have 1 dose for 2011-12	
HIB (prior to age 5 only)					0-14 months; 3-4 doses, 5-59 months; 1 dose	
TUBERCULIN TEST					**Required if traveled to high-risk area**	
ROTAVIRUS (given @ 2-4-6 mo. Not after 12 mos.)						
OTHER						

SCREENING TESTS

Vision: Date:	Hearing: Date:
Distance Acuity Right_____ Left_____	Pure Tone Testing:
Muscle Balance ☐Pass ☐Fail ☐Not Done	Right Ear ☐ Pass ☐ Fail ☐ Not Done
Farsightedness ☐Pass ☐Fail ☐Not Done	Left Ear ☐ Pass ☐ Fail ☐ Not Done
Color ☐Pass ☐Fail ☐Not Done	Child Wears Hearing Aid? ☐ Yes ☐ No
Child Wears Glasses? ☐Yes ☐No	Testing With Hearing Aid? ☐ Yes ☐ No
Tested With Glasses? ☐Yes ☐No	Referral Made? ☐ Yes ☐ No
Referral Made? ☐Yes ☐No	
Specify Test/Equipment:_________________________________	Other Test(specify):____________________________________

SPEECH ASSESSMENT Date:

☐ Child has no discernable speech problem

☐ Child has possible problem with: ☐ Articulation ☐ Rhythm ☐ Voice ☐ Language

Speech evaluation is recommended: ☐ Yes ☐ No

LABORATORY TESTS

**ODH Lead Testing Requirement: ages 6-72 months

☐ Hemoglobin/Hematocrit ☐ Urine Protein ☐ Urine Blood ☐ Urine Glucose ☐ **BLL (Blood Lead Level):____

PHYSICAL EXAMINATION

**Preschool students must have a signed physician exam on file with the school within 30 days of admission, renewed every year while in Preschool. The exam must have been given within the year.

Date of Examination: ____________________________

- ☐ This child is essentially within normal limits
- ☐ This child is not within normal limits

Explain:

Does this child have any physical, developmental or behavioral problems? Suggest special programs, placement or attention that the school can provide.

ACTIVITIES & LIMITATIONS

Can the child participate fully in the following activities?

Classroom and academic activities	☐ Yes ☐ No
Physical Education classes	☐ Yes ☐ No
Competitive Athletics	☐ Yes ☐ No
Contact & Collision Sports	☐ Yes ☐ No

Specify any limitations:

Is this child on any medications? ☐ Yes ☐ No

Explain:

Examiner's Signature: _________________________________ Date signed: _______________

Examiner's Printed Name: ______________________________

Address: ______________________________

____

Phone: ______________________________

(revised 2.15.11 KMS)