

NEWTON ELEMENTARY SCHOOL

Health Record/Physical Examination

Student Name: _____

Date of Birth: _____

Immunizations Required by the Ohio Dept. of Health for School Attendance

DTaP (5) _____

Polio (4) _____

M.M.R. (2) _____

Hepatitis B (3) _____

Varicella (Chicken Pox) (2) _____

Physical Exam: *To be filled in and signed by physician*

Date: _____ Height: _____ Weight: _____ Age: _____ Sex: _____

General Appearance:

Posture: _____

Skin: _____

Eyes: _____

Ears: _____

Nose: _____

Throat (tonsils): _____

Mouth (teeth): _____

Neck: _____

Heart: _____

Blood Pressure: _____

Lungs: _____

Abdomen: _____

Genitalia: _____

Hernia: _____

Neurological: _____

Emotional: _____

Remarks concerning any abnormal findings:

Screenings:

(Pass) (Fail)

(Pass) (Fail)

Vision: Right Eye ☐ ☐

Hearing: Right Ear ☐ ☐

Left Eye ☐ ☐

Left Ear ☐ ☐

Stereopsis ☐ ☐

Color Vision ☐ ☐

May participate Physical Education Program: _____

Restricted Physical Education Program: _____

What medication, if any, is the student taking? _____

Physician's report of Health Finding:

() Entirely within normal limits

() Abnormalities as follows: _____

Signature of Physician: _____

Date: _____