Brecksville-Broadview Heights City School District

ENTRANCE PHYSICAL EXAMINATION
(To Be Completed by Physician)

STUDENT NAME: _____ **DOB:** ___/___/___ **GRADE:** _____

REQUIRED FOR PRESCHOOL, KINDERGARTEN OR FIRST GRADE STUDENTS

IMMUNIZATION INFORMATION

Complete using entire date as follows: mm/dd/yyyy

DTP, DT or DTaP	**1.** _____	**2.** _____	**3.** _____	**4.** _____	**5.** _____
Td or Tdap	**1.** _____	**2.** _____			
Polio IPV/OPV	**1.** _____	**2.** _____	**3.** _____	**4.** _____	**5.** _____
HIB	**1.** _____	**2.** _____	**3.** _____	**4.** _____	
Hepatitis B	**1.** _____	**2.** _____	**3.** _____		
MMR	**1.** _____	**2.** _____			
Varicella (vaccine)	**1.** _____	**2.** _____			
Meningococcal	**1.** _____	**2.** _____			
Other _____	_____	_____			

Immunization Exemption: **Written statement required from parent/guardian or physician. (Ohio Revised Code, Section3313.671)**

EXAMINATION Date: _____ Height: _____ Weight: _____ Blood Pressure: _____

Findings: ☐ All normal or Indicate any **abnormal findings** below.

	Remarks / Recommendations		Remarks / Recommendations
☐ Posture	_____	☐ Heart	_____
☐ Neck	_____	☐ Lungs	_____
☐ Skin	_____	☐ Abdomen	_____
☐ Nervous System	_____	☐ Genitalia	_____
		☐ Hernia	_____

Restrictions: _____

_____

_____

Hearing Type of Test: _____ Results: _____ Comments: _____

Vision Acuity: Right – 20/ _____ Left – 20/ _____ Strabismus: ☐ Yes ☐ No Comments: _____

Dental General dental health: _____ Work indicated: ☐ Yes ☐ No

Chronic Health Concerns: ☐ Asthma ☐ Seizure Disorder ☐ ADD/ADHD ☐ Diabetes ☐ Other: _____

Comments: _____

Medication	**Dosage/Frequency**	**Reason**

Indicate if child was referred to a specialist for any reason (explain): _____

Special Tests (physician's discretion)

Urinalysis _____ Hematocrit _____ Lead _____ Sickle Cell _____

Tuberculin Test Date: _____ Type: _____ Results : ☐ Positive ☐ Negative

Physician Information (Print/Type)

Name _____
Address _____
City/State/Zip _____
Phone _____

Based on examination consistent with EPSDT/Headstart/AAP guidelines, I certify this child to be in suitable condition for enrollment in school.

Signature: _____ ___/___/___

PHYSICIAN SIGNATURE **DATE**

File-School Clinic **1/2016**