

# St. Thomas More School

## Physical Examination

Student's Name		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of birth / /	
Height	Weight	BMI Percentile	BP		

### SCREENING TESTS

Vision	Hearing	Postural
Date Performed / /	Date Performed / /	Date Performed / /
Distance Acuity <input type="checkbox"/> R <input type="checkbox"/> L	Pure Tone	<input type="checkbox"/> No abnormality noted
Muscle Balance <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Right Ear <input type="checkbox"/> Pass <input type="checkbox"/> Fail	<input type="checkbox"/> Screening not done
Stereopsis <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Left Ear <input type="checkbox"/> Pass <input type="checkbox"/> Fail	<input type="checkbox"/> Referral made
Color <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Child wears hearing aid? <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments
Child Wears glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No	Child under the care of a hearing specialist? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Tested with glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No	Referral made? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Referral Made? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Speech/Language	Lead Poisoning
Speech assessment completed <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Date Type <input type="checkbox"/> C <input type="checkbox"/> V Results
Child has no discernible speech problem <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Date Type <input type="checkbox"/> C <input type="checkbox"/> V Results
Speech evaluation recommended <input type="checkbox"/> Yes <input type="checkbox"/> No	
Child has possible problem with _____	<b>Tuberculin Test</b>
	Date Type Results

<b>Health History</b> (Serious or cronic illnesses/injuries/surgeries)

<b>Physical Examination</b> Date of most recent examination / /
<input type="checkbox"/> Essentially normal <input type="checkbox"/> Abnormalities as follows

Is this child able to participate fully in:					
Classroom and academic activities	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Physical education classes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Competition athletics	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Contact and collision sports	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If limitations are advised, please specify					

Does this child have any physical, developmental or behavioral issues that may affect his/her educational process?

<b>HealthCare Provider</b>		
Signature	Print Name	Phone
Address		Date
City	State	Zip