

**ASHLAND-GREENWOOD PUBLIC SCHOOLS  
SCHOOL PHYSICAL EXAMINATION AND VISUAL EVALUATION  
FOR KINDERGARTEN AND OUT-OF-STATE TRANSFER STUDENTS**

DIRECTIONS: A physical examination and a visual evaluation completed within six months prior to school entrance are required by state law for all students entering Kindergarten or transferring from out of state to any grade. All sections of this examination form must be completed prior to its being returned to the school offices. Please note that this form requires signatures for both the physical examination and the visual evaluation before it is considered complete. The physical examination and visual evaluation may be performed by a physician, a physician assistant, or an advanced practice registered nurse; the visual evaluation may also be performed by an optometrist or ophthalmologist. Children are exempt from this requirement when the parent/guardian provides a written statement of objection. For more information about these requirements, including the availability of resources for low-income families, please contact the school nurse in your child's school. For middle school and high school students transferring in from out of state, this completed form will also serve as a sports physical (parent permission form still required).

STUDENT NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY/STATE/ZIP: \_\_\_\_\_

PHONE: \_\_\_\_\_ DoB: \_\_\_\_\_

GRADE: \_\_\_\_\_ GENDER: M F

PHYSICAL EXAMINATION						
HT _____	WT _____	BP _____	/	_____	Pulse _____	
Urinalysis _____						
Hemoglobin/Hct _____						
Audiometric Screening Report						
	500	1000	2000	3000	4000	6000
R	_____	_____	_____	_____	_____	_____
L	_____	_____	_____	_____	_____	_____
EXAM	Normal	Abnormal	Comments			
Thyroid	_____	_____	_____			
Lungs	_____	_____	_____			
Heart	_____	_____	_____			
Abdomen	_____	_____	_____			
Hernia	_____	_____	_____			
Neck	_____	_____	_____			
Upper Extremities	_____	_____	_____			
Back/Spine	_____	_____	_____			
Lower Extremities	_____	_____	_____			
Description of any lab results obtained _____						
_____						
Medication child is currently taking _____						
_____						
I herewith certify that the student named above has been evaluated as indicated by the above record and found to be physically fit to participate in school activities except as noted below. Any exceptions or required modifications should be re-evaluated annually or as specified.						
Modifications or exceptions _____						
_____						
_____			(date)			
(provider signature)						
Provider's Address: _____						
Provider's Phone Number: _____						

VISUAL EVALUATION			
	Pass	Fail	Recommend Further Eval
Amblyopia	_____	_____	_____
Strabismus	_____	_____	_____
Internal Eye Health	_____	_____	_____
External Eye Health	_____	_____	_____
Visual Acuity			
20 feet	Right 20/ _____	Left 20/ _____	aided/unaided
16 inches	Right 20/ _____	Left 20/ _____	aided/unaided
Comments/Recommendations _____			
_____			
_____			
(provider signature)			(date)
Provider's Address: _____			
Provider's Phone Number: _____			

Immunization Record					
	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5
DPT, DtaP, or TD					
Polio					
MMR					
Hepatitis B					
HIB					
Varivax					
Other					

Date (month/year) child had chicken pox \_\_\_\_\_  
(varivax immunization not required if date provided)

TB Test Date \_\_\_\_\_ Results \_\_\_\_\_