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 and advanced practice registered nurse; the visual evaluation may also be performed by an optometrist or opthamologist). 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_____

_____

_____ _____

(provider signature) (date)

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_____