ST. MARY SCHOOL
274 N. Prospect Street
Marion, Ohio 43302
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Email: **school@marionstmary.org**
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Kindergarten Physical Screening

Name of Child:_____ Gender: M____ F_____

Birth Date: _____ Age: _____

Parent Name: _____

Address: _____

_____

Objective Data: Height:_____(____)% Weight:_____(____)% BP:_____

Screening Tests:

Vision:
Distance Acuity: Right _____ Left:_____
Muscle Balance: (Near and Far): Pass_____ Fail_____ Not Done_____
Farsightedness: Pass_____ Fail_____ Not Done_____
Color: Pass_____ Fail_____ Not Done_____
Child wears glasses? Yes_____ No_____
Tested with glasses? Yes_____ No_____
Referral made? Yes_____ No_____
Specify test/equipment_____

Hearing:
Pure tone testing:
Right ear: Pass_____ Fail_____ Not Done_____
Left ear: Pass_____ Fail_____ Not Done_____
Child wears hearing aid? Yes_____ No_____
Tested with hearing aid? Yes_____ No_____
Referral made? Yes_____ No_____
Other test (specify)_____

Speech:
Child has discernable speech problem? Yes_____ No_____
Child has possible problem with:
Articulation _____ Rhythm _____ Voice ___ Language _____
Speech evaluation is recommended? Yes_____ No_____

Laboratory Tests:
Hemoglobin/Hematocrit _____ Urine protein _____ Urine blood ____ Urine glucose _____

Other_____

Physical Examination:
This child is essentially within normal limits_____
This child is essentially not within normal limits _____

Explain:_____

Does this child have any physical, developmental or behavioral problems that would require the school to provide special attention, programs, or placement?

Explain:

Activities and Limitations:

Can the child participate fully in the following activities:

Classroom and academic activities? Yes_____ No_____

Physical Education activities? Yes_____ No_____

Competitive athletics? Yes_____ No_____

Explain any limitations:

Allergies:

Medications:

Food:

Insect bite:

List of Medications (if any):

Immunizations:

DPT 1 _____ 2 _____ 3 _____ 4 _____ 5 _____

Polio 1 _____ 2 _____ 3 _____ 4 _____

Hep B 1 _____ 2 _____ 3 _____

MMR 1 _____ 2 _____

HIB 1 _____ 2 _____ 3 _____ 4 _____

VARICELLA 1 _____ 2 _____

Examiner:

Name: (print)

Address:

Phone:

Signature: Date: