

**Nombre del Estudiante:** \_\_\_\_\_  
**Fecha de Nacimiento:** \_\_\_\_\_ **Marque Uno** [ ] Masculino [ ] Femenina  
**Lugar de Nacimiento:** \_\_\_\_\_  
**Dirección de Casa:** \_\_\_\_\_ **# de Tel:** \_\_\_\_\_

*\*Pre-school and Kindergarten students must have a current (within 1 year) physician's exam on file prior to admission & renewed every year during the named grades\**

**EXAMINATION DATE** \_\_\_\_\_

	Evaluation	Normal	Abnormal	Evaluation	Normal	Abnormal
DOB: _____	Skin			Abdomen & Groin		
Age: _____	Posture/Gait			Genitalia & Urinary		
Weight: _____	Speech/Communication			Bones/Joints		
Height: _____	Head			Neurological		
Lead: _____	Eyes			Gross & Fine Motor		
B.P: _____	Ears			Muscles		
Hematocrit: _____	Nose			Cognitive		
	Mouth/Teeth etc.			Self Help		
	Heart & Circulatory			Social Skills		
	Chest & Lungs			Glands Thyroid/Lymph		
	Weight			Height		

**Vision Screening Results:** LEFT 20/\_\_\_\_\_ RIGHT 20/\_\_\_\_\_ **Hearing Screening Results:** P / F

**Chronic Condition(s):** \_\_\_\_\_ **Allergies:** \_\_\_\_\_

**Immunizations as Required for School Entry by the Ohio Department of Health**

Type:	Dates: Month/Day/Year				
<b>DTaP, DPT or DT</b>					
<b>DT/ Td</b>					
<b>Polio</b>					
<b>MMR</b>					
<b>Hepatitis B</b>					
<b>Varicella</b>					
<b>Hib (prior to age 5)</b>					
<b>Tuberculin Test</b>					
<b>Tdap</b>					
<b>MCV 4</b>					
<b>Other</b>					

*\*This child has been examined and is in suitable condition for participation in group care. The child has had the age appropriate immunizations required by Section 3313.671 of the Ohio Revised Code for admission to school or is to be exempted from immunizations for the following reason(s)*

**Comments: (medications, plan of action, limitations, etc.)** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Examiner's Signature:** \_\_\_\_\_

**Examiner's Printed Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_  
 \_\_\_\_\_

**Telephone & Fax:** \_\_\_\_\_

\*Please return this copy to school or to the Welcome Center\*