Paulding Exempted Village Schools
Pre-School Physical Assessment

Student: _____ **Date of Birth:** _____ **School year**: _____

The Ohio department of education recommends: **Lead level:** _____ **Hematocrit**: _____

Not performed _____ **Not performed** _____

Allergies: _____

Treatment for above noted allergies: _____

General Findings:

General Physical Examination:

Height _____ Weight _____ BMI _____ BP _____

Vision: ☐ Within Normal Limits *Hearing:* ☐ Within Normal Limits

☐ Wears Corrective Lenses ☐ Hearing is Impaired as described: _____

☐ Other: _____ _____

Dental: ☐ No concerns noted

☐ Referred to Dentist; Comments: _____

Speech: ☐ No concerns noted

☐ Speech is Impaired as described: _____

Please evaluate the following: Skin, Head, Nose, Lymphatics, Chest, Neck, Abdomen, Back, Genitalia, and Extremities:

☐ All are within normal limits.

☐ Abnormalities are noted in the following areas, and the treatment plan is as follows: _____

_____

General Neurological Findings:

Describe any concerns in the following areas: Gait, Station, Muscle Power, Muscle Tone, Reflexes, and Cranial Nerves.

☐ All are within Normal Limits

☐ Concerns are noted in the following areas and a treatment plan is as follows: _____

_____

_____

Motor Coordination:

Gross Motor Skills: ☐ Within Normal Limits ☐ Noted Concerns: _____

Fine Motor Skills: ☐ Within Normal Limits ☐ Noted Concerns: _____

Sensory Needs:

Please describe any noted sensory abnormalities and treatment plan.

_____

_____

Medical Diagnoses:

Please note any diagnoses for which you, or a referred physician/specialist, are treating this child.

- ☐ Attention Disorders, please specify: _____
- ☐ Autistic Spectrum Disorders, please specify: _____
- ☐ Mood Disorders, please specify: _____
- ☐ Anxiety Related Disorders, please specify: _____
- ☐ Neurological Impairments, please specify: _____
- ☐ Orthopedic Impairments, please specify: _____
- ☐ Respiratory Disorders, please specify: _____
- ☐ Cardiovascular Disorders, please specify: _____
- ☐ Endocrine Disorders, please specify: _____
- ☐ Social/Emotional Behavior problems: _____
- ☐ Other, please specify: _____

_____

Medications:

Is this child currently being prescribed any medications by you or any other medical personnel? ☐ Yes ☐ No

If Yes, Please Indicate Medication and Dosage: _____

_____

_____

Treatment Plan and Educational Recommendations:

Please note your recommended medical treatment plan (e.g., medications, therapy, etc) and your specific educational recommendations.

_____

_____

_____

_____

Immunizations are up to date (please attach copy of record) ___ Yes ___No

If no state reason why: _____

This is to certify that the above named child has had a complete physical examination and is in suitable condition to fully participate in group care:

Date Completed: _____

Print Name and title of person completing exam: _____

Signature of person completing exam: _____

Address: _____

Phone Number: _____