KINDERGARTEN SCHOOL ENTRANCE EXAM

TAKE THIS FORM TO YOUR PHYSICIAN TO COMPLETE

Return to the Board of Education Office:
24365 Hilliard Blvd.; Westlake, Ohio 44145; (440) 871-7300

Child's Name:_____ Date of Birth: _____ Sex: *_____

Address:_____

PHYSICAL EXAMINATION

Date of Exam: _____ Height: _____ Weight: _____	Eyes: _____ Vision: R: 20/_____ L: 20/_____	Ears: _____ Hearing: Type _____ R: _____ L: _____

Referred to ear or eye specialist: ☐Yes _____ ☐No

Nose: _____ Throat: _____

Mouth: _____ Teeth: _____

Is dental work indicated? ☐Yes _____ ☐No

If so, are plans being made? ☐Yes _____ ☐No

Posture: _____ Skin: _____ Neck: _____ Heart: _____ Abdomen:_____ Genitalia: _____	General Condition:_____ Orthopedic:_____ Nervous System:_____ Lungs: _____ Hernia: _____ Urinalysis: _____

Remarks & Recommendations:

ALLERGIES: (Food/Insect) Reaction and Recommended Treatment:

PLEASE ATTACH A PRINTED COPY OF THE CHILD'S IMMUNIZATION HISTORY.

Physician Name (Please Print): _____

Physician Signature:_____

Street Address:_____ Phone: _____

City/State/Zip: _____ Fax: _____