DELPHOS CITY SCHOOLS PHYSICAL FORM

Franklin Elementary School – 310 East Fourth Street, Delphos, OH 45833

Name: _____ Male/Female DOB: _____

Address: _____ Phone: _____

School Attended Last: _____

Father: _____ Employed: _____

Mother: _____ Employed: _____

TO BE COMPLETED BY PHYSICIAN (Physical must be completed in full to be accepted by school)

Height: _____ **Weight:** _____ **Blood Pressure:** _____

Visual Screening: Distance Acuity: right eye _____ left eye _____

Does the student wear glasses? Yes _____ No _____

Frequent headaches? _____

Hearing Screening: Right Ear _____ Left Ear _____ (Pass or Fail)

Hearing follow up required? _____ Tubes in ears? _____

History of frequent ear infections? Yes _____ No _____

If hearing complications present, please describe: _____

Is pupil subject to any condition which limits?

Classroom activities? Yes _____ No _____ Physical Education? Yes _____ No _____

Competitive athletics? Yes _____ No _____ If yes, describe _____

_____

Diagnosed Medical Conditions: _____

Medications taken during the school year including at home or school: _____

Is this pupil subject to any condition which may result in a classroom emergency: e.g. epilepsy, fainting, diabetes, asthma and so forth? Yes _____ No _____

If yes, describe: _____

Does this child have any allergies? Yes _____ No _____ Describe: _____

Allergy to bee stings? Yes _____ No _____

Is there any emotional, mental, or physical condition for which this pupil should remain under periodic medical observation? (ADHD, AUTISM, ASPERGERS, DEPRESSION, BEHAVIORAL, SPEECH, LEARNING, ATTENTION, ETC.

Yes _____ No _____ Describe: _____

Are Immunizations up to date? Yes _____ No _____

IMMUNIZATIONS AND DATES	REQUIRED DOSES					
Diptheria-Tetanus-Whooping Cough	5					
Polio	4					
MMR	2					
HIB (No HIB after age 5)	3					
Hepatitis B	3					
Tuberculosis Test	(Optional)					
Varicella (Chicken Pox)	2					
Other						

TB Skin Test (required for recent travel out of the country, immigration, etc.) Date: _____ Result: _____

Regular dental examinations: Yes _____ No _____

DATE: _____ SIGNATURE OF PHYSICIAN: _____

Updated: 1/8/2020 Physician Contact #: _____