MCS-204 Rev 1/12

Mason City Schools – For Kindergarten Use Only

Ohio Schools – Physician Report

Child's Name: ______________________ Sex (M) (F) DOB: __________ Date: __________

Objective Data: Height/Weight: ____/____ (required by the State of Ohio for preschool entry) BP: __________

Screening Tests: (required by the State of Ohio for preschool entry)

Vision: ____________________

Distance Acuity:	Right _____	Left _____	
Muscle Balance:	Pass ___	Fail ___	Not Done ___
Farsightedness:	Pass ___	Fail ___	Not Done ___
Color:	Pass ___	Fail ___	Not Done ___
Wears Glasses?	Yes ___	No ___	Not Done ___
Tested w/glasses?	Yes ___	No ___	Not Done ___
Referral made?	Yes ___	No ___	Not Done ___

Hearing: ____________________ Date: __________

Pure Tone Testing:

Right Ear:	Pass ___	Fail ___	Not Done ___
Left Ear:	Pass ___	Fail ___	Not Done ___

Other Tests (specify): ____________________________

Child wears hearing aid? Y / N Tested w/ hearing aid? Y / N

Referral made? Y / N

Blood Screenings (required by the State of Ohio for preschool entry)

Hematocrit: __________ Lead: __________

Allergies: ____

Food Allergies: ____

Physical Examination Date of Exam: ____________________

___ Essentially Normal Abnormalities as follows: ______________________________

Is child able to participate fully in the following:

A.	Classroom and academic activities ?	Y	N
B.	Physical Education Classes ?	Y	N
C.	Competition Athletics ?	Y	N
D.	Contact and Collision Sports ?	Y	N

If limitations are advised, please specify: ______________________________

If this child has any physical, developmental or behavioral problems, how can school assist with special programs, placement or attention?

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IMMUNIZATION INFORMATION

DPT:					
MMR:					
HEP B:					
POLIO:					
VARICELLA:					
Varicella Date of Disease					
HIB:					
TB:					

Physician's Assessment: Problems ?

____

Recommendations?

____

Physician's Name / Address: ______________________________

Physician's Signature: ______________________________