

Paulding Exempted Village Schools

Pre-School Physical Assessment

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

The Ohio department of education recommends: Lead level: _____ Hemoglobin: _____
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: _____