Berea City School District
Immunizations & Physical Examination

Student Name	Male / Female	Date of Birth:	School:

Immunizations (Must be excluded from school if information not provided or student not up-to date)

DPT1 or DT1:	DPT2 or DT2:	DPT3 or DT3:	DPT4 or DT4:	DPT5 or DT5:
OPV1 or IPV1 (circle one):	OPV2 or IPV2 (circle one):	OPV3 or IPV3 (circle one):		OPV4 or IPV4 (circle one):
HIB1	HIB2	HIB3		HIB4
MMR1:	MMR2:	Chickenpox:		Chickenpox:
HBV1	HBV2	HBV3		

		Immunizations Recorded By:
DTP = Diphtheria/Pertussis/Tetanus	DT = Diphtheria/Tetanus	
HIB = Haemophilus B HBV = Hepatitis B	MMR = Measles/Mumps/Rubella	
IPV = Inactivated Polio Vaccine	OPV = Oral Polio Vaccine	

History & Physical Examination

REQUIRED FOR PRESCHOOL -- *Due on admission to program & annually from date of examination.*

(Recommended for kindergarten students)   (WNL = Within Normal Limits)

Examined:	WNL	Comments/Concerns:	Examined:	WNL	Comments/Concerns:
General			Pelvis		
Appearance			Genitalia		
Neurological			Muscular-		
Eyes			Skeletal		
Ears			Skin		
Nose			Height (actual)		
Throat (Tonsils)			Weight (actual)		
Mouth (Teeth)			Blood Pressure		
Neck			Posture, gait		
Heart			Growth &		
Lungs			Development		
Abdomen			Speech		

VISION--RIGHT EYE	VISION--LEFT EYE	HEARING--RIGHT EAR	HEARING--LEFT EAR
		1000 Hz (20 dB HL) Pass Fail	1000 Hz (20 dB HL) Pass Fail
20/	20/	2000 Hz (20 dB HL) Pass Fail	2000 Hz (20 dB HL) Pass Fail
Color: Pass Numbers Pass Trails Fail		4000 Hz (20 dB HL) Pass Fail	4000 Hz (20 dB HL) Pass Fail

Labs and Results

Hematocrit _____% date _____	Lead _____mcg/dl date _____

Comments:

Child is free from apparent communicable disease and is in suitable condition to attend a preschool program.		
Date of Examination	Physician Signature	Printed/Stamped Name of Physician

Please return completed form to: School Office or Clinic