A-35-3 (rev.12/19)

Worthington Schools
Physician's Report

Child's Name_____Male____Female____Age_____Date of Birth_____

PHYSICAL EXAMINATION: Date of Exam_____

Height_____ (%) Weight_____ (%) BP_____

Vision Acuity R_____ L_____ Corrective Lenses: Glasses_____ Contacts_____ None_____
Vision Referral needed? yes_____ no_____

Hearing Acuity R_____ L_____ Hearing Aids: yes_____ no _____
Hearing Referral needed? yes_____ no_____

Posture screening results pass_____ fail_____ PPD results _____ Urinalysis results _____

Has this child had any hospitalizations, injuries, surgeries, or serious medical illnesses? yes_____ no_____
Does this child have any chronic medical conditions? yes_____ no_____
Does this child have any food, medication or environmental allergies? yes_____ no_____
Does this child have any life threatening allergies requiring an Epipen at school? yes_____ no_____
Does this child have required medication to be taken during the school day? yes_____ no_____

If yes was indicated above please provide an explanation and details below:

_____

_____

_____

Is this child able to participate fully in the following?

- Classroom and academic activities: yes____ no____ If "no" please give details below
- Physical education classes: yes____ no____ If "no" please give details below

_____

_____

Do you have any other information or concerns about this child's physical or emotional health, growth and development, behavior or family circumstances that you feel the school should be aware of?_____

_____

_____

_____

Physical Examination: Essentially normal_____ Abnormalities as follows: _____

_____

_____

_____

I certify that I have on this date examined this student. On the basis of this examination requested by the school authorities and the student's medical history as furnished to me, I have found no reason that would make it medically inadvisable for this student to complete in supervised athletic activities, except as noted above. I certify that the student is free from communicable disease.

PLEASE PRINT OR STAMP

Physician's name_____ Physician's signature ***(REQUIRED)*** _____
Address_____ Date signed_____
Phone_____