NORWOOD CITY SCHOOL DISTRICT 2024-25

Pre-School

Ohio School History

Physician Assessment

Name: _____ Gender: _____ Age:_____ DOB: _____

Ethnicity: ☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian American ☐ Other

Objective Data:

Height_____ Weight: _____ B.P.:_____

IMMUNIZATION Required for school entry						
TYPE	DATE: MO/DAY/YEAR					
DtaP, DPT or DT						5th dose required if 4th dose given before 4th b-day for **Kindergarten**
DT/Td					**Grades 1-12*:** 4 doses of DtaP, DTP, DT or Td or any combination **Grade 7-12: 1 dose of Tdap or Td prior to entry**	
POLIO					**K-11** students must have 3 or more doses of IPV, final dose on or after 4th bday; 4 doses if a combination of OPV/IPV. **Grades 12** 4 doses if combination IPV/OPV. 4 doses if all IPV/OPV & if the final dose was given before 4th birthday	
MMR					**KG-12**: 2 doses required for 2024-25	
HEPATITIS B					**K-12**: 3 doses required for 2024-25	
VARICELLA					**K-11** must have 2 doses for 2024-25 **Gr 12** must have 1 dose for 2024-25	
HIB (prior to age 5 only)					0-14 months; 3-4 doses, 5-59 months; 1 dose	
TUBERCULIN TEST					**Required if traveled to high-risk area**	
ROTAVIRUS (given @ 2-4-6 mo. Not after 12 mos.)						
MCV4					**Gr 7-11 must have 1 dose for 2024-25** **Gr 12 must have 2 doses for 2024-25**	

SCREENING TESTS

Vision: Date:	Hearing: Date:
Distance Acuity Right_____ Left_____ Muscle Balance ☐Pass ☐Fail ☐Not Done Farsightedness ☐Pass ☐Fail ☐Not Done Color ☐Pass ☐Fail ☐Not Done Child Wears Glasses? ☐Yes ☐No Tested With Glasses? ☐Yes ☐No Referral Made? ☐Yes ☐No Specify Test/Equipment:_____	**Pure Tone Testing:** Right Ear ☐ Pass ☐ Fail ☐ Not Done Left Ear ☐ Pass ☐ Fail ☐ Not Done Child Wears Hearing Aid? ☐ Yes ☐ No Testing With Hearing Aid? ☐ Yes ☐ No Referral Made? ☐ Yes ☐ No Other Test(specify):_____

SPEECH ASSESSMENT Date:

☐ Child has no discernable speech problem

☐ Child has possible problem with: ☐ Articulation ☐ Rhythm ☐ Voice ☐ Language

Speech evaluation is recommended: ☐ Yes ☐ No

Physician Assessment *(CONTINUED)*

LABORATORY TESTS

**ODH Lead Testing Requirement: ages 6-72 months

☐ Hemoglobin/Hematocrit ☐ Urine Protein ☐ Urine Blood ☐ Urine Glucose
☐ **BLL (Blood Lead Level): _____

PHYSICAL EXAMINATION

**Preschool students must have a signed physician exam on file with the school within 30 days of admission, renewed every year while in Preschool. The exam must have been given within the year.

Date of Examination: _____

- ☐ This child is essentially within normal limits
- ☐ This child is not within normal limits

Explain:

Does this child have any physical, developmental or behavioral problems? Suggest special programs, placement or attention that the school can provide.

ACTIVITIES & LIMITATIONS

Can the child participate fully in the following activities?

Classroom and academic activities	☐ Yes	☐ No
Physical Education classes	☐ Yes	☐ No
Competitive Athletics	☐ Yes	☐ No
Contact & Collision Sports	☐ Yes	☐ No

Specify any limitations:

Is this child on any medications? ☐ Yes ☐ No

Explain:

Examiner's Signature: _____ Date signed: _____

Examiner's Printed Name: _____

Address: _____

_____

Phone: _____

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