Margaretta Local School District
Medical/Physical Form

Student's Name	Date of Birth	Gender ☐ Male ☐ Female

Date of Examination	Height	Weight	BMI	BP

VISION SCREENING

Distance Acuity	☐ R	☐ L
Muscle Balance	☐ Pass	☐ Fail
Stereopsis	☐ Pass	☐ Fail
Farsightedness	☐ Pass	☐ Fail
Color	☐ Pass	☐ Fail
Wear glasses?	☐ Yes	☐ No
Referral made?	☐ Yes	☐ No
Screening not done	☐	

HEARING SCREENING

Pure Tone		
Right ear	☐ Pass	☐ Fail
Left ear	☐ Pass	☐ Fail
Wears hearing aid?	☐ Yes	☐ No
Under the care of hearing specialist?	☐ Yes	☐ No
Referral made?	☐ Yes	☐ No
Screening not done	☐	

POSTURAL SCREENING

☐ No abnormality found
☐ Screening not done
☐ Referral made

Comments:

SPEECH/LANGUAGE ASSESSMENT

☐ Normal Speech Pattern ☐ Possible problem with: ☐ articulation ☐ rhythm ☐ voice ☐ language
☐ Speech evaluation recommended ☐ Speech assessment not done

Did the examination reveal any abnormalities or concerns in the following areas?

	YES	NO		YES	NO
General Appearance			Heart		
Skin			Lungs		
Lymph Nodes			Abdomen		
Eyes/Vision			Genitalia		
Nose/Throat			Skeletal System		
Ears/Hearing			Neuro Muscular		
Teeth/Gums/Dental			Tongue/Palate		
Allergies			*Specify		

☐ Essentially normal ☐ Abnormalities as follows: _____

_____

Is this child able to participate fully in:

Classroom and academic activities? ☐ Yes ☐ No Physical education classes? ☐ Yes ☐ No
Competition athletics? ☐ Yes ☐ No Contact and collision sports? ☐ Yes ☐ No

If limitations are advised, please specify: _____

_____

Does this child have any physical, developmental, or behavioral concerns that may affect his/her educational process?

_____

_____

List any serious or chronic illnesses/injuries/surgeries: _____

_____

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****Immunization Report Must Be Attached****

Immunizations	Circle One		Exempt from Immunizations	Circle One	
Complete for Age	Yes	No	Religious Conviction	Yes	No
In Process	Yes	No	Health Concern	Yes	No

****Required for Preschool or Preschool Special Education Program****

Assessment & Screenings	Circle One		Date Completed	Results
Lead	Yes	No		
Hemoglobin	Yes	No		

Physician's Signature	Print Name	Phone
Address		Date Signed
City	State	Zip Code