HEALTH SERVICES DEPARTMENT

School Entry Physical Examination

TO BE COMPLETED BY PHYSICIAN

HT _____ WT _____ Bp _________ LEAD TEST: Date___/___/___ [ ] capillary or [ ] venous Result _____

*Lead testing only if physician deems applicable

NORM. | ABNORM. | REMARKS
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Eyes | Vision: RT | LT
ENT
Lungs
Heart
Abdomen
Hernia
Extremities
Neuro
Skin

Other conditions/disabilities: ________________________________

Urine (if applicable): Alb _____ Sugar _____ Should child be restricted from any activities? [ ] yes [ ] no If yes, explain.

Physician’s signature ___________________________ Date ___________________________