Mayfield City School District
Student Health Services

Physician's Report of Physical Examination

Grades K-12

Student's Name: _____ Gender M F DOB: _____ Age: _____

Parent/guardian: _____ Phone: _____

Height: _____ (%ile) **Weight:** _____ (%ile) BMI: _____ %ile

Does this child have any dietary restrictions? ____ Please List:_____

Vision Screening: Date ____/____/____
Distance Acuity R____ L____
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 for failure? Yes __ No __

Hearing Screening: Date ____/____/____
Audiometric Thresholds:
Right ear Pass __ Fail __ Not Done __
Left ear Pass __ Fail __ Not Done __
Other Tests (specify) _____
Child wears hearing aid? Yes __ No __
Tested with hearing aid? Yes __ No __
Referral Made? Yes __ No

Dental screening: Date _____/_____/____ Any abnormalities?_____
Was a referral made for dental care?_____

Review of Systems
Cardiovascular _____ Pulse: _____ B.P.: ____/____
Speech & Language _____ Musculoskeletal _____
Nasopharynx _____ Neurological _____
Thyroid _____ Renal/Urinalysis _____
Genitalia _____ Respiratory _____
GI/Hernia _____

Please attach additional forms as needed, for medical conditions which will require specific attention, such as seizure disorder, diabetes, life-threatening allergies, medication administration. Forms available at www.mayfieldschools.org under Student Health Services.
Does this child have allergies? _____
Does this child have a seizure disorder? _____
Other physical abnormalities or medical conditions the school should be aware of and special instructions, if necessary: _____
Is this child on any medications? No __ Yes __ If yes, the name and purpose for administration:
_____
Is this child able to participate fully in the following?
a. Physical education activities Yes __ No __
b. Swimming Yes __ No __
c. Horseback riding Yes __ No __
If limitations are advised, please specify those limitations: _____
_____

***Immunization History Required**: Please attach record.
CDC Tuberculin Risk Survey Date: ___/___/___ not at risk ____ at risk _____
TB Skin Test (done in U.S.): Date applied___/___/___read___/___/___
Type: Results: ___ Action:_____

Based upon the medical history and physical condition at the time of this examination, this child is free from apparent communicable disease and is ready for enrollment in school. Yes ____ No ____

_____ _____ ____/_____/____
Physician's Stamp/ or printed name Physician's Signature ***Date of Exam**

revised 5/2011