



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 _____