KINDERGARTEN SCHOOL ENTRANCE EXAM

TAKE THIS FORM TO YOUR PHYSICIAN TO COMPLETE

24525 Hilliard Blvd., Westlake, Ohio 44145, (440) 871-7300

Child's Name:_____ Date of Birth: _____ Sex: _____

Address:_____

PHYSICAL EXAMINATION

Date of Exam:_____ Height: _____ Weight: _____	Eyes: _____ Vision: R: 20/_____ L: 20/_____	Ears: _____ Hearing: Type _____ R: _____ L: _____

Referred to ear or eye specialist: Yes _____ No_____

Nose: _____ Throat: _____

Mouth: _____ Teeth: _____

Is dental work indicated? Yes_____ No_____

If so, are plans being made? Yes_____ No_____

Posture: _____ Skin: _____ Neck: _____ Heart: _____ Abdomen:_____ Genitalia: _____	General Condition:_____ Orthopedic:_____ Nervous System:_____ Lungs: _____ Hernia: _____ Urinalysis: _____

Remarks & Recommendations:

ALLERGIES: (Food/Insect) Reaction and Recommended Treatment:

PLEASE ATTACH A PRINTED COPY OF THE CHILD'S IMMUNIZATION HISTORY.

Physician Name (Please Print): _____

Physician Signature:_____

Street Address:_____ Phone: _____

City/State/Zip: _____ Fax: _____