MARIEMONT City Schools

PHYSICIAN'S REPORT

Dear Parents/Physicians:
Note the vision and hearing screening portion of this form (as well as the immunizations) MUST be completed by the physician before the child enters kindergarten.

Date of Exam_____

Physical Assessment: (please check)

_____ entirely within normal limits

_____ concerns:

Speech Assessment: (please check)

_____ no problems

_____ possible problems (list below)

Is there any reason why the student cannot carry out a full program of school work?

Yes_____ No_____

School Health Examination Record

School_____Grade_____

Student_____ Birth Date_____

Father or Guardian's Name_____ Business Phone_____
Place of Employment

Mother or Guardian's Name_____ Business Phone_____
Place of Employment

Describe any health conditions, severe injuries, illnesses, surgical procedures and hospitalizations your child has or had in the past (include allergies and/or reactions to medications, food or any substance and the recommended treatment if the allergy is severe).

List any medications that your child takes daily or frequentl

Please add any comments or concerns you have about your child that you would like the school to be aware of.

Physician's Name_____Office Phone_____Signature_____

Immunization
Indicate month/day/year

Type	Date	Date	Date	Date	Date
DTP					
TD					
Polio					
MMR					
Measles					
Rubella					
Mumps					
HBV					
HIB					
Varicella					
Other Identify					

Vision Screening Tests
ALL Screenings required for Kindergarten

	Right	Left
Distance Acuity		

	Distance	Near
Muscle Balance	Pass / Fail	Pass / Fail
Stereopsis	Pass / Fail	Pass / Fail
Color Vision (boys only)	Pass / Fail	Pass / Fail

Hearing Screening Test
Required for Kindergarten

1000 Hz @ 20 db HL	Pass / Fail
2000 Hz @ 20 db HL	Pass / Fail
4000 Hz @ 20 db HL	Pass / Fail