SOUTH EUCLID LYNDHURST SCHOOLS
The Destination School Community

PHYSICAL FORM

IT IS RECOMMENDED THAT CHILDREN HAVE A COMPLETE MEDICAL EXAMINATION BEFORE ENTERING SCHOOL. A CURRENT IMMUNIZATION RECORD IS REQUIRED AT THE TIME OF REGISTRATION. THE IMMUNIZATIONS AND TESTS BELOW ARE REQUIRED BY STATE LAW AT THE TIME OF REGISTRATION IN A SCHOOL DISTRICT.
IF PRESCHOOL ENROLLMENT, please return to the School Psychologist at Rowland Elementary School.
All other enrollments, please EMAIL the SEL District Nurse at healthservices@sel.k12.oh.us

PLEASE FILL IN CHILD'S NAME, ADDRESS AND SCHOOL BEFORE PRESENTING TO YOUR DOCTOR

Child's Name_____ School_____

Address_____ Birthdate_____

PHYSICAL EXAMINATION RECORDS **DATE OF EXAMINATION:**_____

Height_____ Weight_____ Eyes_____ Ears_____

Vision: Rt_____ Lt_____ Hearing: Rt_____ Lt_____

Referred to ear or eye specialist? _____Yes _____No

Nose_____ Throat_____ Mouth_____ Teeth_____

Is dental work indicated? _____Yes _____No

Posture_____ General Condition_____

Skin_____ Orthopedic_____

Neck_____ Nervous System_____

Heart_____ Lungs_____

Abdomen_____ Hernia_____

Genitalia_____ Urinalysis_____

Is child in suitable condition to attend school? _____Yes _____No
Remarks and Recommendations:_____

IMMUNIZATION REQUIREMENTS (Please give month, day, year)

DPT	**#1**	**#2**	**#3**	**#4**	**#5**
Polio	**#1**	**#2**	**#3**	**#4**	
MMR	**#1**	**#2**			
Hep B	**#1**	**#2**	**#3**		
Varicella K-11: 2 doses Gr.12: 1 dose	**#1**	**#2**			
Tdap Booster Grades 7 - 12	**#1**				
Meningococcal Grades 7 - 12	**#1**	**#2**			

SIGNATURE of Healthcare Provider_____ **DATE**_____

Healthcare Provider Name (PRINT / STAMP)_____ **Phone Number**_____