SCHOOL ENTRANCE MEDICAL EXAMINATION

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 eat 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-10: 2 doses 11–12: 1 dose	**#1** ________	**#2** ________			
Tdap Booster Grades 7 - 12	**#1** ________				
Meningococcal Grades 7 - 11 and Grade 12	**#1** ________	**#2** ________			

SIGNATURE of Healthcare Provider_________________________________**DATE**______________

Healthcare
Provider Name (PRINT / STAMP)_____________________________**Phone Number**___________

August 12, 2020