

**ALL CMSD STUDENTS ARE REQUIRED TO HAVE A YEARLY PHYSICAL**

**Cleveland Municipal School District  
Physical Examination Report  
(To Be Completed by Physician)**

Child's Name	DOB	Sex M      F	Age	Date of Exam
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**Objective Data**

Height	Weight	B.P.      /	Pulse
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**Screening Tests**

Vision		Date:	Hearing		Date:
Distance Acuity	Right _____	Left _____	Right Ear	Pass _____	Fail _____
Muscle Balance	Pass _____	Fail _____	Left Ear	Pass _____	Fail _____
Farsightedness	Pass _____	Fail _____	Other Tests (specify) _____		
Color	Pass _____	Fail _____	_____		
Child wears glasses?	Yes _____	No _____	_____		
Tested with glasses?	Yes _____	No _____	Hearing Aid?	Yes _____	No _____
Referral made?	Yes _____	No _____	Referral Made?	Yes _____	No _____

**Speech /Language**

Speech Assessment:	Done _____	Not Done _____	No discernable problem _____
Possible problem with:	_____		Evaluation recommended: _____

**Laboratory Tests**

Hematocrit/Hemoglobin _____	Urine protein _____	Urine glucose _____
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**Lead Levels** \_\_\_\_\_ **Age test done?** \_\_\_\_\_

**Physical Examination:** Note any abnormalities with explanation

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\_\_\_\_\_

\_\_\_\_\_

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\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Illnesses and Injuries:** List any serious illnesses or injuries

Illness/ Injury	Child's age	Hospitalized
_____	_____	_____
_____	_____	_____
_____	_____	_____

Comments: \_\_\_\_\_

Date of Last Dental Exam: \_\_\_\_\_ Findings: \_\_\_\_\_

Name of Physician	Address (Physician Please Stamp Form)	Phone Number
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