Seymour Community Schools
School Physical Examination Form

Child's Name ____

School Child will be attending ______________________________ Date of Birth ______________

(code: No Defect 0 Defect – Note)

Height______ Weight______

Head___________________

Eyes___________________

Nose___________________

Throat__________________

Heart___________ BP____________

Lungs__________________

Abdomen_______________

Posture________________

Operations_____________________________

____

Serious Illness / Injury___________________

DTP/DT/TD
DtaP
1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________
6. ______________________

Pollo
1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________

MMR
1. ______________________
2. ______________________

HEPATITIS A 1. ______________ 2 ______________

HBV
1. ______________________
2. ______________________
3. ______________________

VARICELLA
1. ______________
2. ______________

CHICKEN POX DISEASE Yes____ No____ Date_______

Is there a condition which should be considered in planning this child's school program?

____

____

Date of Exam_________________ Signed ______________________________________

Seymour Community Schools
Dental Examination Form

(Code: No defect 0 defect – Note)

TEETH: Cavities__________________________ Malocclusions___________________________

Present Status: Restorations____

Appointments Scheduled___________________ Recommendations___________________________

Date of Exam___________________________ Signed____________________________________

Seymour Community Schools
Student Vision Form

Child's Name____

Address____Date of Birth_________________

Parent /Guardian____

School child will be attending____

1. Visual Acuity Pass Fail

	Distance		Near	
Undecided	R. eye 20/	L. eye 20/	R. eye 20/	L. eye 20/
Corrected	R. eye 20/	L. eye 20/	R. eye 20/	L. eye 20/

Remarks____

2. Refractive Error Pass Fail
Remarks____

3. Ocular Health Pass Fail
Remarks____

4. Eye Muscle Balance Pass Fail
Remarks____

5. Binocular Depth Perception Pass Fail
Remarks____

6. Accommodation (Focusing Ability) Pass Fail
Remarks____

7. Color Perception Pass Fail
Remarks____

8. Other____

- Analysis of Vision and Eye Health____
- Recommendations__________________No treatment Indicated__________Glasses /Contacts________
- Prescribed______________Present Prescription Satisfactory___________Vision Therapy_____________
- Other____
- Glasses /Contacts should be worn (if prescribed): Always______Desk Work Only______Far Vision______
- Re-Examination Required______________________

I certify that this child's vision and eye health have been examined and are sufficient to enter Kindergarten.

Date of Exam________________ Signed____