Abdomen

Extremities

Neurological Exam

Mental development assessment

Medical diagnosis

Is this child subject to any condition limiting classroom or physical activities?  ___ No  ___ Yes
If "Yes”, describe

Is this child taking any medication?  ___ No  ___ Yes  if "Yes”, list medications

List concerns/remarks


HEARING SCREENING:

<table>
<thead>
<tr>
<th>Audio Test</th>
<th>500Hz</th>
<th>1000Hz</th>
<th>2000Hz</th>
<th>4000Hz</th>
</tr>
</thead>
<tbody>
<tr>
<td>Right Ear—dB</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Left Ear——dB</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

VISION EXAM required for Kindergarten and students transferring from outside of NE

Tests | Pass | Fail | Recommend Further Examination (See Comments Below)

Amblyopia |     |     |        |
Strabismus |     |     |        |
Internal Eye Health |     |     |        |
External Eye Health |     |     |        |

Visual Acuity Right 20/_____ Left 20/_____ with/without glasses

Comments/Recommendations/Restrictions

Date of PE

Signature of Licensed Health Care Provider

Office Phone #