Abdomen ______________________________ Back ______________
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: _______Pass _____Fail Referral______________

Audio Test	500Hz	1000Hz	2000Hz	4000Hz
Right Ear---dB	______	______	______	______
Left Ear ----dB	______	______	______	______

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 # _______________