

Part II - COMPREHENSIVE PHYSICAL EXAMINATION REPORT

Part II to be completed by a qualified licensed physician. All components, unless otherwise indicated, are to be performed no earlier than twelve months prior to the date child enters kindergarten or elementary school. Ref. Code of Virginia § 22.1-270, A-H.

Student's Name: _____
Last First Middle
 Date of Birth: / / Height: _____ Weight: _____ Head Circumference: _____ Blood Pressure: _____
Mo. Day Yr.

Hemoglobin: _____ gms or Hematocrit: _____ % Urine: Albumin _____, Sugar _____, Other _____
 Results of Mantoux tuberculin skin test, optional (may be required in high-risk groups): _____ mm. Date of test: / /
Mo. Day Yr.

If performed, date of most recent blood lead level: / / Results: _____ µg/dL
Mo. Day Yr.

Vision Screening
 Distance visual acuity screening results, without correction: Right Eye 20/ _____ Left Eye 20/ _____ Both Eyes 20/ _____
 Distance visual acuity screening results, with correction: Right Eye 20/ _____ Left Eye 20/ _____ Both Eyes 20/ _____
 If performed, stereopsis screening results: Pass _____ Fail _____
 Child to be rescreened? Yes , No Child to be referred? Yes , No

Hearing
 Hearing screening results: Right Ear _____ Left Ear _____ Equipment used: _____
 If performed, hearing evaluation results: Right Ear _____ Left Ear _____
 If indicated, Tympanogram: Normal _____ Abnormal _____
 Child to be rescreened? Yes , No Child to be referred? Yes , No

| Systems Examination | Examined | Not Examined | Comments About Findings |
|--------------------------------|----------------------------------|--------------|-------------------------|
| General Appearance | | | |
| Nutritional Status | | | |
| Posture / Motor Behavior | | | |
| Skin | | | |
| Head | | | |
| Eyes: | External | | |
| | Fundi | | |
| Ears: | External and Canal | | |
| | Tympanic Membrane | | |
| Nose | | | |
| Throat | | | |
| Mouth / Teeth | | | |
| Neck | | | |
| Heart | | | |
| Lungs | | | |
| Abdomen | | | |
| Genitalia (Tanner Stage) | | | |
| Bones, Joints, Muscles | | | |
| Neurological | | | |
| Estimated Developmental Level: | Cognitive Development | | |
| | Speech / Language Development | | |
| | Social / Emotional Development | | |
| | Health Behaviors / Health Habits | | |
| Other: | | | |

Summary of abnormal physical findings, if any: _____

Medical diagnoses: _____

Describe specifically what, if any, conditions are found that would identify the child as having a disability, including conditions that might require (1) educational evaluation, (2) environmental adjustment, or (3) activity limitation: _____

Assessment: _____

Recommendations and referrals made, if any: _____

Physician's Address: _____ City: _____ State: _____ Zip: -
 Physician's Name (print): _____ Phone No. --
 Signature of Physician: _____ Date (Mo., Day, Yr.): / /

