5411 MainStreet
Sylvania,OH 43560
419-882-6670
www.stjosephschoolsylvania.org

SAINT JOSEPH
PARISH SCHOOL

Physician's Report for Kindergarten (to be completed by physician)

Child's Name_____ Age _____ years_____mos.

Immunization Requirements: at least 5 DPT, 4 polio, 2 MMR, 3 or 4 Hep. B, 2 Varicella, and 4 HIB (The fourth dose of polio administered on or after the fourth birthday)

DPT 1._____ 2._____ 3._____ 4._____ 5._____

Polio 1._____ 2._____ 3._____ 4._____

MMR 1._____ 2._____

HIB 1._____ 2._____ 3._____ 4._____

Hep B 1._____ 2._____ 3._____ 4._____

Varicella 1._____ 2. _____

Other Type_____ Date_____ Type_____ Date_____

Screening Tests:

Vision (pass/fail):
Distance acuity R_____ L_____
Muscle balance R_____ L_____
Farsightedness R_____ L_____
Color (Circle) Pass / Fail
Wears glasses? Yes / No
Referral made? Yes / No

Hearing (pass/fail):
Pure Tone R_____ L_____
Impedance R_____ L_____
Frequent Ear Infections? _____
Does child have tubes? _____
Right_____ (date placed)
Left _____ (date placed)

Allergies:(food, plant, animal, drug)_____
_____

Physical Exam:

Essential Normal _____ Abnormalities as follows _____
_____
Is this child able to participate in all school activities? Yes _____ No _____
If no, please explain: _____
This is to certify that the above named student has been seen in our office and is in suitable condition to attend a preschool or kindergarten program.

(PRINT OR STAMP BELOW)

Physician Signature _____ Physician name _____
Date of exam _____ Address _____
Phone _____

REACHING OUT IN SERVICE TO ALL