MATER DEI ACADEMY

2024-2025

***PHYSICAL EXAM***

Name Birthdate

Address

**\*\* Attach immunization record or provide dates below per ORC 3313.37/3313.671**

PHYSICAL EXAMINATION RECORD

Pupils enrolled for the first time must have a physical exam per ORC 3313.673.

**Date of Exam: SEX: Male Female**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Recommended Assessments/Screenings** | | | | |
| *Vision* | *See attached form* | Lead | yes | no |
| Hearing | Hemoglobin | yes | no |
| Other |  | Dental | yes | no |

|  |  |
| --- | --- |
| Height |  |
| Weight |  |
| Blood Pressure |  |
| BMI |  |

|  |  |  |  |
| --- | --- | --- | --- |
| NORMAL | ABNORMAL |  | Comments: |
|  |  | Head, face and scalp |  |
|  |  | Teeth |  |
|  |  | Nose and sinus |  |
|  |  | Eyes | Allergies: |
|  |  | Ears |  |
|  |  | Mouth and Throat |  |
|  |  | Neck (Thyroid) |  |
|  |  | Chest and Lungs | Medications: |
|  |  | Heart |  |
|  |  | Abdomen |  |
|  |  | Genitalia |  |
|  |  | Back, Extremities | Restrictions regarding physical sports or activities: |
|  |  | Skin |  |
|  |  | Rectum, Anus |  |
|  |  | Neurological |  |

**PLEASE PRINT OR STAMP**

**Physician’s Name**

**Physician’s Signature**

Address City/State/Zip

Telephone Date Signed