

# PHYSICAL FORM: EC – Grade 5

(Form H - 5)

To be completed by physician



Andrews Osborne  
ACADEMY

**Deadline: August 1, 2009**

Student's Name \_\_\_\_\_ Male \_\_\_ Female \_\_\_ Birth Date \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ BMI percentile \_\_\_\_\_ BP \_\_\_\_\_

**Allergies:** \_\_\_\_\_

<b>Vision</b>	<b>Hearing</b>	<b>Postural</b>
Date performed _____	Date Performed _____	Date Performed _____
Distance Acuity ___ R ___ L	Pure Tone	___ No abnormality noted
Muscle Balance ___ Pass ___ Fail	Right Ear ___ Pass ___ Fail	___ Screening not done
Stereopsis ___ Pass ___ Fail	Left Ear ___ Pass ___ Fail	___ Referral Made
Color ___ Pass ___ Fail	Child wears hearing aid? ___ Yes ___ No	Comments _____
Child wears glasses? ___ Yes ___ No	Child under care of a	_____
Tested with glasses? ___ Yes ___ No	hearing specialist? ___ Yes ___ No	_____
Referral made? ___ Yes ___ No	Referral made? ___ Yes ___ No	_____

<b>Speech Language</b>	<b>Lead Poisoning</b>
Speech assessment completed ___ Yes ___ No	Date _____ Type ___ C ___ V Results _____ hg/dL
Child has no discernible speech problem ___ Yes ___ No	Date _____ Type ___ C ___ V Results _____ hg/dL
Speech evaluation recommended ___ Yes ___ No	

<b>HCT Results</b> (preschool only) _____	<b>Tuberculin Test</b> Date _____ Type _____ Results _____
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**Health History** (Please indicate previous medical conditions & surgeries, serious or chronic illnesses, and current health issues.)

\_\_\_\_\_

\_\_\_\_\_

**Physical Examination: Date of most recent examination** \_\_\_\_\_

\_\_\_ Essentially normal \_\_\_ Abnormalities as follows: \_\_\_\_\_

\_\_\_\_\_

Is this child able to participate fully in:

Classroom and academic activities	___ Yes ___ No	Physical education classes	___ Yes ___ No
Competition athletics	___ Yes ___ No	Contact and collision sports	___ Yes ___ No

If limitations are advised, please specify \_\_\_\_\_

\_\_\_\_\_

Does this child have any physical, developmental, or behavioral issues that may affect his/her educational process?

\_\_\_\_\_

Health Care Provider's Signature _____	Date _____
Print Name _____	Phone _____
Address _____	
City _____	State _____ Zip _____