## SECTION III -- PHYSICAL EXAMINATION, INSPECTION, TESTS, AND MEASUREMENTS

**EXAMINATIONS AND/OR INSPECTIONS** 

TESTS AND MEASUREMENTS   Wide   United   Normal   United   Normal   United   Care   Referred   United   Normal   United   Care   Referred   United   Unite	ESSENTIAL FINDINGS DEVIATING FROM NORM	MAL AND/OF	RECOMM	ENDATIONS						
Mathin   Notice   Referred   Notice   Referred   Notice   Referred   Notice   Notice   Notice   Care   Referred   Care   Vision Tested?   Vision Tested at or an entitle to represent the same intervals at National Tested at or an entitle to represent the vision Tested at or an entitle v										
Mathin   Number   Referred   Re										
Wilhin   Norter   Referred   Re										
Mathin   Number   Referred   Re										
Normal   Normal   Normal   Care			TESTS AN	ID MEASURE	MENTS					
Vision Tested?   Visual Activity   Unrids   Unrids   Unridspiss Done?   Sugar   Unit				Referred					Referred	
Yes   No			Carc					Outc		
Date   Gibbor   Date   Date   Microscopic   Date   Microscopic   Date   Microscopic   Date   Microscopic   Date   Microscopic   Date   Microscopic   Date   Date	Vision Tested? ☐ Visual Activity				Urinalysis Done?	☐ Sugar				
Hearing Tested?   Audiometer	☐ Yes ☐ No ☐ Muscle Imbalance				☐ Yes ☐ No	Albumin				
Hearing Tested?   Audiometer	Date Other(Specify)				Date	☐ Microscopic				
Reading   Read					Blood Pressure Measure	ed?				
Reading					☐ Yes ☐ No					
Ves   No   Other:   Other:   Blood Lead Level Tested?   Blood Lead Level Tested?   Blood Lead Level Tested?   Blood Lead level recommended for all children enrolled in Medicaid must be tested at one and two years of age, or once between three and sk years of age if not previously tested. All children under age ski living in high risk areas should be tested at the same intervals as noted above.  ESSENTIAL FINDINGS DEVIATING FROM NORMAL AND/OR RECOMMENDATIONS  Tuberculin Test (if given) Date					Reading					
Ves   No   Other:   Other:   Blood Lead Level Tested?   Blood Lead Level Tested?   Blood Lead Level Tested?   Blood Lead level recommended for all children enrolled in Medicaid must be tested at one and two years of age, or once between three and sk years of age if not previously tested. All children under age ski living in high risk areas should be tested at the same intervals as noted above.  ESSENTIAL FINDINGS DEVIATING FROM NORMAL AND/OR RECOMMENDATIONS  Tuberculin Test (if given) Date	Homoglobin/Homotocrit Toctod?				Hoight	Woight				
Blood Lead Level Tested?   Yes   No   Blood Lead level recommended for all children enrolled in Medicaid must be tested at one and two years of age, or once between three and six years of age in not previously tested. All children under age and six years of age in not previously tested. All children under age as noted above.  ESSENTIAL FINDINGS DEVIATING FROM NORMAL AND/OR RECOMMENDATIONS    Tuberculin Test (if given)   Date   Type   Negative   Positive   mmm.	-					vveignt				
was be tested at one and two years of age, or once between three and six years of age if not previously tested. All children under age six living in high risk areas should be tested at the same intervals as noted above.    ESSENTIAL FINDINGS DEVIATING FROM NORMAL AND/OR RECOMMENDATIONS		1				mandad for all 1915	on roll!	10 di ' '		
BESENTIAL FINDINGS DEVIATING FROM NORMAL AND/OR RECOMMENDATIONS  Tuberculin Test (if given) Date					must be tested at one ar	nd two years of age, or	once between	en three		
ESSENTIAL FINDINGS DEVIATING FROM NORMAL AND/OR RECOMMENDATIONS  Tuberculin Test (if given) Date Type Negative Positive mmm.  SECTION IV - RECOMMENDATIONS  Is there ary defect of vision, hearing, or other condition for which the school could help by sealing or other action? Yes No If yes, check below and explain degree of restriction: Classroom Playground Cymnasium Swimming Pool Competitive Sports Camp Other  Examiner's Signature Date Examiner's Name (print or type) Degree or License  Number & Street City Zip Telephone  SECTION V - DENTAL EXAMINATION AND RECOMMENDATIONS (OPTIONAL)  I have examined teeth and make the following recommendations as for treatment:  Child's Name  Dentits's Signature Date										
Tuberculin Test (if given)  Date	Date Result					ac cca.a 20 toctoa at t		0.74.0		
Is there any defect of vision, hearing, or other condition for which the school could help by seating or other action?										
Classroom Playground Gymnasium Swimming Pool Competitive Sports Camp Other  Examiner's Signature Date Examiner's Name (print or type) Degree or License  Number & Street City Zip Telephone  SECTION V DENTAL EXAMINATION AND RECOMMENDATIONS (OPTIONAL)  I have examined teeth and make the following recommendations as for treatment:  Child's Name  Dentist's Signature Date		ich the school c	could help by s	seating or other act	ion? Yes No					
Classroom Playground Gymnasium Swimming Pool Competitive Sports Camp Other  Examiner's Signature Date Examiner's Name (print or type) Degree or License  Number & Street City Zip Telephone  SECTION V DENTAL EXAMINATION AND RECOMMENDATIONS (OPTIONAL)  Thave examined teeth and make the following recommendations as for treatment:  Child's Name  Dentist's Signature Date										
Examiner's Signature  Date  Examiner's Name (print or type)  Degree or License  Number & Street  City  Zip  Telephone  SECTION V DENTAL EXAMINATION AND RECOMMENDATIONS (OPTIONAL)  I have examined  Leeth and make the following recommendations as for treatment:  Child's Name  Dentist's Signature  Date	Should the student's activity be restricted because of any phy	sical defect or il	Iness?   Ye	es 🗌 No If yes,	check below and explain degree	e of restriction:				
Number & Street  City  Zip Telephone  SECTION V DENTAL EXAMINATION AND RECOMMENDATIONS (OPTIONAL)  I have examined  teeth and make the following recommendations as for treatment:  Child's Name  Dentist's Signature  Date	☐ Classroom ☐ Playground ☐ C	Symnasium	□ Sı	vimming Pool	☐Competitive Sports	☐ Camp ☐ Other				
Number & Street  City  Zip  Telephone  SECTION V DENTAL EXAMINATION AND RECOMMENDATIONS (OPTIONAL)  I have examined  teeth and make the following recommendations as for treatment:  Child's Name  Dentist's Signature  Date										
SECTION V DENTAL EXAMINATION AND RECOMMENDATIONS (OPTIONAL)  I have examined teeth and make the following recommendations as for treatment:  Child's Name  Dentist's Signature Date	aminer's Signature Date Examiner's Name (print or type)					Degree or License				
SECTION V DENTAL EXAMINATION AND RECOMMENDATIONS (OPTIONAL)  I have examined teeth and make the following recommendations as for treatment:  Child's Name  Dentist's Signature Date	mber & Street City		Zip			Telephone				
I have examined teeth and make the following recommendations as for treatment:  Child's Name  Dentist's Signature Date	SECTION V DENTAL EXAMINATION AN	D RECOM		ONS (OPTIO	NAL)	<u> </u>		•		
Child's Name  Dentist's Signature Date	OLOTION V DENTAL EXAMINATION AN	D IVECOM	WENDAII	OHO (OF HO	IVAL)					
				teeth a	nd make the following recomme	ndations as for treatment:				
	Ciliu S Ivanie									
						Dentist's Signature		Date		
	COMMENTS					,				

MDCH/OCAL-3305 (formerly BRS-3305)

Rev. July 2007