## Part III -- COMPREHENSIVE PHYSICAL EXAMINATION REPORT

**A qualified licensed physician, nurse practitioner, or physician assistant must complete Part III**. The exam must be done no longer than one year before entry into kindergarten or elementary school (Ref. Code of Virginia § 22.1-270). Instructions for completing this form can be found at www.vahealth.org/schoolhealth.

Student's Name: _____ Date of Birth:_____/_____/_____Sex: M F

### Health Assessment

**Date of Assessment:** ____/____/_____

Weight:_____lbs. Height:_____ft._____in.

Body Mass Index (BMI):_____BP_____

❑ Age / gender appropriate history completed

❑ Anticipatory guidance provided

**Physical Examination**

1 = Within normal 2 = Abnormal finding 3 = Referred for evaluation or treatment

| | 1 | 2 | 3 | | 1 | 2 | 3 | | 1 | 2 | 3 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| HEENT | | | | Neurological | | | | Skin | | | | |
| Lungs | | | | Abdomen | | | | Genital | | | | |
| Heart | | | | Extremities | | | | Urinary | | | | |

### Tuberculosis Screening

Check the box that applies:

| ☐ No risk for TB infection identified | ☐ No symptoms compatible with active TB disease | ☐ Risk for TB infection or symptoms identified |
|---|---|---|

Test for TB Infection: TST IGRA Date: TST Reading mm TST/IGRA Result: ☐ Negative ☐ Positive

CXR required if positive test for TB infection or TB symptoms. CXR Date:_____ ☐ Normal ☐ Abnormal

**EPSDT Screens Required for Head Start – include specific results and date:**

Blood Lead:_____ Hct/Hgb _____

### Developmental Screen

| *Assessed for:* | *Assessment Method:* | *Within normal* | *Concern identified:* | *Referred for Evaluation* |
|---|---|---|---|---|
| Emotional/Social | | | | |
| Problem Solving | | | | |
| Language/Communication | | | | |
| Fine Motor Skills | | | | |
| Gross Motor Skills | | | | |

### Hearing Screen

❑ Screened at 20dB: Indicate Pass (P) or Refer (R) in each box.

❑ Screened by OAE (Otoacoustic Emissions): ☐ Pass ☐ Referred

| | 1000 | 2000 | 4000 |
|---|---|---|---|
| R | | | |
| L | | | |

☐ Referred to Audiologist/ENT ☐ **Unable to test – needs rescreen**

☐ Permanent Hearing Loss Previously identified: ☐ Left ☐ Right

☐ Hearing aid or another assistive device

### Vision Screen

☐ With Corrective Lenses (Check if yes)

| Stereopsis ☐ Pass ☐ Fail | | | | ☐ Not tested |
|---|---|---|---|---|
| Distance | Both | R | L | Test used: |
| | 20/ | 20/ | 20/ | |
| | | | | |

☐ Pass ☐ Referred to eye doctor ☐ **Unable to test-needs rescreen**

### Dental Screen

☐ Problems Identified: Referred for Treatment

☐ No Problem: Referred for prevention

☐ No Referral: Already receiving dental care

☐ **Unable to perform**

### Recommendations to (Pre) School, Child Care, or Early Intervention Personnel

**Summary of Findings (check one):**

☐ Well child; no conditions identified of concern to school program activities

Conditions identified that are important to schooling or physical activity (complete sections below and/or explain here):

_____

____**Allergy:** ☐ food:_____ ☐ insect:_____ ☐ medicine:_____ ☐ other:_____

*Type of allergic reaction:* ☐ *anaphylaxis* ☐ *local reaction* *Response required:* ☐ *none* ☐ *epinephrine auto-injector* ☐ other::_____

____I**ndividualized Health Care Plan needed** (e.g., asthma, diabetes, seizure disorder, severe allergy, etc)

____**Restricted Activity Specify:** :_____

____**Developmental Evaluation** ☐ Has IEP ☐ Further evaluation needed for: _____

____**Medication.** Child takes medicine for specific health condition(s). ☐ Medication must be given and/or available at school.

____**Special Diet Specify:** _____

____**Special Needs Specify:**_____

**Other Comments:**_____

**Health Care Professional's Certification (Write legibly or stamp)** ☐ **By checking this box, I certify with an electronic signature that all of the information entered above is accurate (enter name and date on signature and date lines below).**

**Name:**_____ **Signature:**_____

**Practice/Clinic Name:** _____ **Address:**_____

**Phone:**_____-_____-_____ **Fax:** _____-_____-_____ **Email:**_____