EAST TROY COMMUNITY SCHOOL DISTRICT

Committed to the Growth & Success of Each Student, Each Year

PHYSICAL AND VISION EXAMINATION REPORT

SCHOOL INFORMATION

◯ Little Prairie Primary School	◯ Prairie View Elementary School	◯ East Troy Middle School	◯ East Troy High School
2109 Townline Rd, East Troy	2131 Townline Rd, East Troy	3143 Graydon Ave, East Troy	3128 Graydon Ave, East Troy
P: 262-642-6730, F: 262-642-2724	P: 262-642-6720, F: 262-642-6788	P: 262-642-6740, F: 262-642-6743	P: 262-642-6760, F: 262-642-6776

STUDENT INFORMATION

Student's Name: _____ Date of Birth: _____ Gr: _____ Sex: ◯ M ◯ F

Physician's Name: _____ Phone #: _____ Fax #: _____

Physician's Address: _____ City: _____ St: _____ Zip: _____

PHYSICAL INFORMATION - TO BE COMPLETED BY THE PHYSICIAN

Height: _____ Weight: _____ Ears: R: _____ L: _____

☐ Normal	Abdomen		☐ Normal	Mouth & Throat	
☐ Normal	Albumin		☐ Normal	Neck	
☐ Normal	Emotional Stability		☐ Normal	Neuro-Muscular	
☐ Normal	Heart		☐ Normal	Nose	
☐ Normal	Hematocrit		☐ Normal	Posture	
☐ Normal	Hemoglobin		☐ Normal	Scalp	
☐ Normal	Hernia		☐ Normal	Skin	
☐ Normal	Lungs		☐ Normal	Sugar	
☐ Normal	Lymph Glands		☐ Normal	Urine	

Activity Limitations: _____

List Medications: _____

Remarks/Recommendations: _____

Summary of Defect(s): _____

Physician's Signature: _____ Date: _____

VISION EXAMINATION - The State of WI encourages parents of 4K/New 5K students to arrange for their child's eyes to be examined by an optometrist or evaluated by a physician. This should include, at a minimum, the elements listed below.

Physician's Name: _____ Phone #: _____ Fax #: _____

Physician's Address: _____ City: _____ St: _____ Zip: _____

(By checking the box, the examining doctor is indicating that the element checked was performed.)

- ☐ Brief history (general health and eye health of the child, including family history
- ☐ General external observation of the child's eyes and surrounding structures
- ☐ Ophthalmoscopic examination through an undilated pupil
- ☐ Gross measurement of peripheral vision
- ☐ Evaluation of eye coordination and function (alignment and motility)
- ☐ Visual acuity for each eye (separately)

Findings: _____

☐ **Follow up vision care for this child is recommended**

Physician's Signature: _____ Date: _____