

GRANDVIEW HEIGHTS CITY SCHOOLS PHYSICAL EXAM REPORT

Student's Name _____ DOB _____ Male _____
 Female _____
 Height _____ Weight _____ BP _____

SCREENING TESTS

Distance Acuity	R _____	L _____	Glasses _____	Not Done
Muscle Balance @ Near	Pass	Fail	Not Done	
Muscle Balance @ Distance	Pass	Fail	Not Done	
Color	Pass	Fail	Not Done	
Hearing (right)	Pass	Fail	Not Done	
Hearing (left)	Pass	Fail	Not Done	

PHYSICAL EXAM

Essentially Normal _____ Abnormalities as follows:

Significant medical or surgical history

Current health problems or medication

1. _____

1. _____

2. _____

2. _____

3. _____

3. _____

Please list any immunizations given on this date:

PHYSICIAN'S NAME

PHYSICIAN'S SIGNATURE

DATE OF EXAM

PLEASE ATTACH A COPY OF THE IMMUNIZATION RECORD.

REV 01_07