COMPREHENSIVE PHYSICAL EXAMINATION REPORT

A qualified licensed physician, nurse practitioner, health practitioner or physician assistant must complete CPER. The exam must be done no longer than one year before entry school.

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

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	☐	☐	☐

TB Screening: ☐ 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: ☐ Positive ☐ Negative
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				

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

❑ Problem Identified: Referred for treatment
❑ No Problem: Referred for prevention
❑ No Referral: Already receiving dental care

Recommendations to Care, or Early Intervention Personnel

Summary of Findings (check one):
☐ **Well, 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: ____________

___**Individualized 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**. 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 signature that all of the information entered above is accurate (enter name and date on signature and date lines below).**

Name: ______________________ **Signature:** ______________________ Date: ____/_____/______

Practice/Clinic Name: ______________________ **Address**: ______________________

Phone: _______-_______-____________ **Fax**: _______-_______-____________ **Email:** ______________________