ILM ACADEMY

2024-2025
Physical Examination Requirements

New Students: All grade levels are required to submit a most recent annual physical examination form from their physician's office, immunization records & this attached screening form.

Current Students: Current ILM students entering the following grades: ML3, 1st, 3rd, 5th, 7th and 8th grade must submit the attached screening form.

All Students: All students enrolling for the 2024-2025 academic year MUST submit their most current immunization records **DUE DATE: July 10, 2024**.

2024-2025 Screening Form

The following screenings are required by the Texas Department of State Health Services, screenings must be completed by a physician and uploaded to School Pro. **DUE DATE: July 31st, 2024**

VISION / HEARING*: Required for children who will turn 4 years old by September 1st 2024, and any students entering Montessori Level 3 (KG), 1st, 3rd, 5th, 7th Grade Students, and All New Students.*

SCOLIOSIS (SPINAL SCREENING)*: Required for GIRLS entering 5th & 7th Grade & BOYS entering 8th Grade.*

Student Name: _____

Gender: _____ Grade: _____ Date of Birth: _____

(Please refer to the back of this form for the report of results)

REPORT OF RESULTS

To be completed by a physician, physician assistant, or nurse practitioner

Vision:

Screened with contacts or glasses? (circle one) Y / N

Right Eye: 20/___ Pass _____ Fail _____
Left Eye: 20/___ Pass _____ Fail _____

If Failed, please fill in the following:

Referral: Y/N Referral Date: _____ Referred to: _____

Hearing:

Screened with Hearing Aids? (circle one) Y / N

Right Ear: Pass _____ Fail _____
Left Ear: Pass _____ Fail _____

If Failed, please fill in the following:

Referral: Y / N Referral Date: _____ Referred to: _____

Scoliosis Spinal Screening (*required for GIRLS entering 5th & 7th Grade & BOYS entering 8th Grade)*:

Spinal screening performed (circle one): Visual / X-ray / Not Completed

Results: _____

If Failed, please fill in the following:

Referral: Y / N Referral Date: _____ Referred to: _____

Physician Name (printed): _____ Phone: _____

Physician Signature: _____ Date: _____