OHIO SCHOOL HEALTH RECORD
PHYSICIAN'S REPORT

Child's Name _____ Male _____ Female _____ Age _____ Date_____

OBJECTIVE DATA:

Height _____ (%) Weight _____ (%) B.P. _____

SCREENING TESTS: Date done _____

Vision
Distance Acuity R_____ L_____
Muscle Balance pass _____ fail _____ not done _____
Farsightedness pass _____ fail _____ not done _____
Color pass _____ fail _____ not done _____
Child wears glasses? yes_____ no_____
Tested with glasses? yes_____ no_____
Referral made? yes_____ no_____

Hearing Date done _____
Audiometric thresholds:
R - ear pass _____ fail _____ not done _____
L - ear pass _____ fail _____ not done _____
Other tests (specify) _____
_____
Child wears hearing aid? yes_____ no_____
Tested with hearing aid? yes_____ no_____
Referral made? yes_____ no_____

SPEECH/LANGUAGE

Speech assessment: done _____ not done _____
Child has no discernible speech problem _____
Child has possible problem with:
Disorders: (check) Articulation _____ Rhythm _____ Voice _____ Language _____
Speech evaluation recommended: yes _____ no _____

LABORATORY TESTS

Hematocrit/Hemoglobin _____ Urine protein _____ Urine blood _____ Urine glucose _____ Other: _____

PHYSICAL EXAMINATION: Date examined _____ Essentially normal _____ Abnormalities as follows:

_____
_____
_____
_____

Is this child able to participate fully in the following?

A. Classroom and academic activities? yes _____ no _____
B. Physical education classes? yes _____ no _____
C. Competitive athletics? yes _____ no _____
D. Contact and collision sports? yes _____ no _____

If limitations are advised, please specify those limitations:

_____
_____
_____

OHIO SCHOOL HEALTH RECORD
PHYSICIAN'S REPORT

If this child has any physical, developmental or behavioral problems, how can the school assist with special programs, placement or attention?

_____

_____

_____

PHYSICIAN'S ASSESSMENT

Problem list	Recommendation for school management
1.	1.
2.	2.
3.	3.

IMMUNIZATION RECORD

Type	Date (month/day/year)					
DTP						
TD						
Polio						
MMR						
Hepatitis B						
Varicella						
HIB						
Prevnar						
Other (Identify)						

PLEASE PRINT OR STAMP

Physician's name_____ Physician's signature_____

Address_____

Phone_____ Date signed_____