

# Ohio Department of Health • School and Adolescent Health

## Physical Examination

Student's name		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth / /
Height	Weight	BMI percentile	BP

### Screening Tests

Vision	Hearing	Postural
Date performed / /	Date performed / /	Date performed / /
Distance Acuity <input type="checkbox"/> R <input type="checkbox"/> L Muscle Balance <input type="checkbox"/> Pass <input type="checkbox"/> Fail Stereopsis <input type="checkbox"/> Pass <input type="checkbox"/> Fail Color <input type="checkbox"/> Pass <input type="checkbox"/> Fail Child wears glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No Tested with glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No Referral made? <input type="checkbox"/> Yes <input type="checkbox"/> No	Pure Tone Right ear <input type="checkbox"/> Pass <input type="checkbox"/> Fail Left ear <input type="checkbox"/> Pass <input type="checkbox"/> Fail Child wears hearing aid? <input type="checkbox"/> Yes <input type="checkbox"/> No Child under the care of a hearing specialist <input type="checkbox"/> Yes <input type="checkbox"/> No Referral made? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> No abnormality noted <input type="checkbox"/> Screening not done <input type="checkbox"/> Referral made Comments _____ _____ _____

### Speech/Language

Speech assessment completed  Yes  No

Child has no discernible speech problem  Yes  No

Speech evaluation recommended  Yes  No

Child has possible problem with \_\_\_\_\_

### Lead Poisoning

Date \_\_\_\_\_ Type  C  V Results \_\_\_\_\_ µg/dL

Date \_\_\_\_\_ Type  C  V Results \_\_\_\_\_ µg/dL

### Tuberculin Test

Date \_\_\_\_\_ Type \_\_\_\_\_ Results \_\_\_\_\_

### Health History (Serious or chronic illnesses/injuries/surgeries)

### Physical Examination Date of most recent examination / /

Essentially normal  Abnormalities as follows

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Is this child able to participate fully in:

Classroom and academic activities <input type="checkbox"/> Yes <input type="checkbox"/> No	Physical education classes <input type="checkbox"/> Yes <input type="checkbox"/> No
Competition athletics <input type="checkbox"/> Yes <input type="checkbox"/> No	Contact and collision sports <input type="checkbox"/> Yes <input type="checkbox"/> No

If limitations are advised, please specify

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Does this child have any physical, developmental or behavioral issues that may affect his/her educational process?

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HealthCare Provider's signature	Print name	Phone ( )
Address		Date / /
City	State	ZIP

# Ohio Department of Health • School and Adolescent Health

## Immunization Report

Student's name	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth / /
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Students are required to be immunized in accordance with Ohio law (Ohio Revised Code 3313.67/3313.671)  
 A copy of the child's immunization record may be attached or dates may be entered below.  
 Please note the month, day, and year for each immunization should be on record.

Vaccine	Record complete dates (month, day, year) of vaccine doses given					
Diphtheria, Tetanus, Pertussis (DTP)						
DTaP, Tdap						
DT, Td						
Polio						
Hepatitis B (HBV)						
Measles, Mumps, Rubella (MMR)						
Varicella (Chickenpox)						
Hepatitis A						
Meningococcal (MCV4, MPSV4)						
Pneumococcal (PCV)						
Measles (Rubeola) only						
Rubella only						
Mumps only						
Haemophilus influenza Type b (Hib)						
Influenza						
Other						

This information was provided by     Health Care Provider     Parent/Guardian     Other \_\_\_\_\_

Signature	Print name	Date / /
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