OHIO SCHOOL HEALTH RECORD

Physician's Report

Child's Name	Sex	Age	Date
	☐ Male ☐ Female		

OBJECTIVE DATA

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

SCREENING TESTS

VISION	DATE:					HEARING	DATE:				
Distance Acuity						**Pure Tone Testing**					
Muscle Balance	☐	pass	☐	fail	☐ Not done	Right ear	☐	pass	☐ fail	☐	Not done
Farsightedness	☐	pass	☐	fail	☐ Not done	Left ear	☐	pass	☐ fail	☐	Not done
Color	☐	pass	☐	fail	☐ Not done	Other tests (specify)					
Child wears glasses	☐	yes	☐	no	☐						
Tested with glasses	☐	yes	☐	no	☐	Child wears hearing aid	☐	yes	☐ no		
Referral made	☐	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:	☐	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:**

s this child able to participate fully in the following:

A. Classroom and academic activities?	☐	yes	☐	No	C. Competition Athletics?	☐	yes	☐	no
B. Physical Education Classes?	☐	yes	☐	No	D. Contact and collision sports?	☐	yes	☐	no

f limitations are advised, please specify those limitations:

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

PHYSICIAN'S REPORT (continued)

PHYSICIAN'S ASSESSMENT

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

PLEASE PRINT OR STAMP

Physician's name	Physician's signature
Address	
Phone	Date Signed:

IMMUNIZATION RECORD

TYPE	DATE(S)				
DPT	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
TD	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
POLIO	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
MEASLES (Rubeola)	___/___/___	___/___/___			
RUBELLA	___/___/___	___/___/___			
MUMPS	___/___/___	___/___/___			
MMR Combined	___/___/___	___/___/___			
OTHER HEP B	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
OTHER VARICELLA	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___