OHIO SCHOOL HEALTH RECORD
PHYSICIAN'S REPORT

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

OBJECTIVE DATA

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

SCREENING TESTS

Date performed _____

Vision	Hearing
Distance Acuity R _____ L _____	Audiometric thresholds:
Muscle Balance pass _____ fail _____ not done _____	R – ear pass _____ fail _____ not done _____
Farsightedness pass _____ fail _____ not done _____	L – ear pass _____ fail _____ not done _____
Color pass _____ fail _____ not done _____	Other tests (specify) _____
Child wears glasses? yes _____ no _____	Child wears hearing aid? yes _____ no _____
Tested with glasses? yes _____ no _____	Tested with hearing aid? yes _____ no _____
Referral made: 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:

_____

_____

_____

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. _____

2. _____

3. _____

4. _____

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

PLEASE PRINT OR STAMP

Physician's name _____ Physician's signature _____

Address _____

Phone _____ Date signed _____