

**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	Lead Poisoning
Speech assessment completed <input type="checkbox"/> Yes <input type="checkbox"/> No Child has no discernible speech problem <input type="checkbox"/> Yes <input type="checkbox"/> No Speech evaluation recommended <input type="checkbox"/> Yes <input type="checkbox"/> No Child has possible problem with _____	<input type="checkbox"/> Date _____ Type <input type="checkbox"/> C <input type="checkbox"/> V    Results _____ µg/dL <input type="checkbox"/> Date _____ Type <input type="checkbox"/> C <input type="checkbox"/> V    Results _____ µg/dL <b>Tuberculin Test</b> Date _____ Type _____ Results _____

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

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**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 School Health Record

## Immunizations

Student's name	Today's date / /
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Immunizations					
Type	Date (Month/Day/Year)				
DTaP DPT or DT					
DT/Td					
POLIO					
MMR					
HEPATITIS B					
VARICELLA					
HIB (prior to age 5 only)					
TUBERCULIN TEST					
ROTOVIRUS					
OTHER					
OTHER					

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