

OHIO SCHOOL HEALTH FORM
Physician's Report

School _____
 Date Enrolled _____ Gr _____

Student's Legal Last Name	First Name	Middle Name

Date of Physical Examination: _____ Today's Date _____

Screening Data

Vision	Date	Hearing	Date
Distance Acuity Right _____ Left _____		Pure tone testing:	
Muscle Balance <input type="checkbox"/> Pass <input type="checkbox"/> Fail <input type="checkbox"/> Not done		Right ear <input type="checkbox"/> Pass <input type="checkbox"/> Fail <input type="checkbox"/> Not done	
Stereopsis <input type="checkbox"/> Pass <input type="checkbox"/> Fail <input type="checkbox"/> Not done		Left ear <input type="checkbox"/> Pass <input type="checkbox"/> Fail <input type="checkbox"/> Not done	
Color <input type="checkbox"/> Pass <input type="checkbox"/> Fail <input type="checkbox"/> Not done		Student wears hearing aid? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Student wears glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No		Testing with hearing aid? <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	
Referral Made? <input type="checkbox"/> Yes <input type="checkbox"/> No		Other Test (specify)	

Speech Assessment Date: _____

- Student has no discernible speech problem
 Student has possible problem with: Articulation Rhythm Voice Language
 Speech evaluation is recommended: Yes No

Objective Data

Height	Weight	BP
--------	--------	----

Laboratory Tests:

- Hemoglobin/Hematocrit Urine Protein Urine Blood Urine glucose
 Other: _____

Physical Exam:

- Physical Exam essentially within normal limits.
 Physical Exam is not within normal limits.

Explain: _____

Does this student have any physical, developmental, or behavioral problems? Yes No
 If yes, please suggest special programs, placement or attention that the school can provide.

Activities & Limitations:

Can the student participate fully in the following activities?

- | | | |
|------------------------------------|------------------------------|-----------------------------|
| Classroom and academic activities? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Physical Education classes | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Competitive Athletics | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Contact and collision sports | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Medications: Is this student on any medications? Yes No

Explain: _____

Immunizations given at this examination _____

Physician's Signature: _____ Date signed _____

Physician's Printed Name: _____

Address: _____ Phone No: _____