

Ohio School Health Record PHYSICIAN'S REPORT

Child's Name _____	Sex	Male	Female	Age _____	Date _____
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Objective Data:

Height _____ (_____ %)	Weight _____ (_____ %)	B.P. _____ / _____
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SCREENING TESTS:

Vision - Date _____

Distance Acuity right _____ left _____

Muscle Balance pass fail not done

Farsightedness pass fail not done

Color pass fail not done

Child wears glasses? yes no

Tested with glasses? yes no

Referral made? yes no

Hearing - Date _____

Pure tone testing:

Right ear pass fail not done

Left ear pass fail not done

Other tests (specify) _____

Child wears hearing aid? 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

Physical Examination:

Date examined: _____

Essentially normal. Abnormalities as follows: _____

Is this child able to participate in the following:

A. Classroom and academic activities: yes no

B. Physical Education classes? yes no

C. Competition 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. _____	1. _____
2. _____	2. _____
3. _____	3. _____

Please print or stamp:

Physician's name: _____	Physician's signature: _____
Address: _____	Date signed: _____

Phone No.: _____	

Must be turned in to the school office