Ohio School Health Record **PHYSICIAN FORM for Kindergarten Students** **rev 04/12**

Child's Name	Sex	Age	Date of Birth

Objective Data:

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

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 follow: _____
_____
_____

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:
_____
_____
_____

Physician's Assessment:

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

Physician Name: _____ Physician Signature: _____

Physician Address: _____

Date: _____