

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	Pure Tone		<input type="checkbox"/> No abnormality noted	
Muscle Balance	<input type="checkbox"/> Pass <input type="checkbox"/> Fail	Right ear	<input type="checkbox"/> Pass <input type="checkbox"/> Fail	<input type="checkbox"/> Screening not done	
Stereopsis	<input type="checkbox"/> Pass <input type="checkbox"/> Fail	Left ear	<input type="checkbox"/> Pass <input type="checkbox"/> Fail	<input type="checkbox"/> Referral made	
Color	<input type="checkbox"/> Pass <input type="checkbox"/> Fail	Child wears hearing aid?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comments	
Child wears glasses?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Child under the care of a hearing specialist	<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				

Speech/Language

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

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

Physical Examination Date of most recent examination / /

<input type="checkbox"/> Essentially normal <input type="checkbox"/> Abnormalities as follows	

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	

Does this child have any physical, developmental or behavioral issues that may affect his/her educational process?	

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

Ohio Department of Health • School and Adolescent Health

Immunization Report

Student's name	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth / /
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Students are required to be immunized in accordance with Ohio law (Ohio Revised Code 3313.67/3313.671).
 A copy of the child's immunization record may be attached or dates may be entered below.
 Please note the month, day, and year for each immunization should be on record.

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

This information was provided by ☐ Health Care Provider ☐ Parent/Guardian ☐ Other _____

Signature	Print name	Date / /
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