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 ☐Pass ☐Fail ☐ Not done	Right ear ☐Pass ☐Fail ☐ Not done
Stereopsis ☐Pass ☐Fail ☐ Not done	Left ear ☐Pass ☐Fail ☐ Not done
Color ☐Pass ☐Fail ☐ Not done	Student wears hearing aid? ☐Yes ☐No
Student wears glasses? ☐Yes ☐No	Testing with hearing aid? ☐Yes ☐No
Tested with glasses? ☐Yes ☐No	Referral Made? ☐Yes ☐No
Referral Made? ☐Yes ☐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.

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Activities & Limitations:

Can the student participate fully in the following activities?

Classroom and academic activities?	☐Yes	☐No
Physical Education classes	☐Yes	☐No
Competitive Athletics	☐Yes	☐No
Contact and collision sports	☐Yes	☐No

Medications: Is this student on any medications? Yes No

Explain:____

Immunizations given at this examination________________________________

Physician's Signature:______________________**Date signed**__________

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Physician's Printed Name:

____

Address: ______________________________**Phone No:**__________

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