School Health Record

School _____

Physician's Report

Child's name	Sex □ Male □ Female	Age	Date

Objective data

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

Screening Tests

VISION	Date		
Distance Acuity	right _____	left _____	
Tested with glasses?	□ yes	□ no	
Muscle Balance	□ pass	□ fail	□ not done
Farsightedness	□ pass	□ fail	□ not done
Random Dot E	□ pass	□ fail	□ not done
Color vision with pseudo-isochromic plates	□ pass	□ fail	□ not done
Child wears glasses?	□ yes	□ no	
Glasses worn for:	□ distance	□ reading	□ at all times
Referral made?	□ yes	□ no	

HEARING	Date		
Pure tone testing	(20 dB @ 1000, 2000, 4000 Hz)		
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		

Laboratory Tests

□Hematocrit /Hemoglobin	□ Urine protein	□ Urine blood	□ Urine glucose	□ Other:_____

Physical Examination:

Date examined

_____

□ Essentially normal Abnormalities as follows: _____

_____

_____

_____

_____

Is this child able to participate fully in the following:

A. Classroom and academic activities? □ yes □ no C. Competitive athletics? □ yes □ no

B. Physical education classes? □ 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?

_____

_____

_____

School Health Record

Medications:

If this child is taking any medication, please list medication and reason for taking:	
Medication	Reason for taking

Immunizations: **Ohio Law describes minimum requirements for school entrance.**

Type:	Record Month/Day/Year				
DTaP, DPT, DT	_____	_____	_____	_____	_____
Td, TDaP	_____				
Polio, OPV, IPV	_____	_____	_____	_____	
MMR	_____	_____			
Hepatitis B	_____	_____	_____	_____	
Varivax (chickenpox)	_____	_____ (date of vaccine or disease)			
HIB	_____	_____	_____	_____	
Prevnar (pneumococcal)	_____	_____	_____	_____ Recommended.	
TB Test	_____ Result: Neg. _____ or Pos._____ Optional				
Other_____	_____				

Please print or stamp:

Doctor's name	Doctor's signature
Address	Date signed
Phone	