

Ohio Department of Health • School and Adolescent Health

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

Speech/Language

Lead Poisoning

Speech assessment completed <input type="checkbox"/> Yes <input type="checkbox"/> No Child has no discernible speech problem <input type="checkbox"/> Yes <input type="checkbox"/> No Speech evaluation recommended <input type="checkbox"/> Yes <input type="checkbox"/> No Child has possible problem with _____	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td><input type="checkbox"/> Date _____</td> <td>Type <input type="checkbox"/> C <input type="checkbox"/> V</td> <td>Results _____ µg/dL</td> </tr> <tr> <td><input type="checkbox"/> Date _____</td> <td>Type <input type="checkbox"/> C <input type="checkbox"/> V</td> <td>Results _____ µg/dL</td> </tr> </table> <p>Tuberculin Test Date _____ Type _____ Results _____</p>	<input type="checkbox"/> Date _____	Type <input type="checkbox"/> C <input type="checkbox"/> V	Results _____ µg/dL	<input type="checkbox"/> Date _____	Type <input type="checkbox"/> C <input type="checkbox"/> V	Results _____ µg/dL
<input type="checkbox"/> Date _____	Type <input type="checkbox"/> C <input type="checkbox"/> V	Results _____ µg/dL					
<input type="checkbox"/> Date _____	Type <input type="checkbox"/> C <input type="checkbox"/> V	Results _____ µg/dL					

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

Physical Examination Date of most recent examination / /

Essentially normal 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