

Ohio School Health Record Physician's Report

N

Northmont City Schools
4001 Old Salem Road
Englewood, Ohio 45322

167,000
02/04
Side 1

Child's Name	Sex	<input type="checkbox"/> Male	<input type="checkbox"/> Female	Age	DOB
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Objective Data

Height	(%)	Weight	(%)	B.P.	/
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Screening Tests

Vision	Date	Hearing	Date
Distance Acuity	right _____ left _____	Pure tone testing	
Muscle Balance	<input type="checkbox"/> pass <input type="checkbox"/> fail <input type="checkbox"/> not done	Right ear	<input type="checkbox"/> pass <input type="checkbox"/> fail <input type="checkbox"/> not done
Farsightedness	<input type="checkbox"/> pass <input type="checkbox"/> fail <input type="checkbox"/> not done	Left ear	<input type="checkbox"/> pass <input type="checkbox"/> fail <input type="checkbox"/> not done
Color	<input type="checkbox"/> pass <input type="checkbox"/> fail <input type="checkbox"/> not done	Other tests (specify) _____	
Child wear's glasses?	<input type="checkbox"/> yes <input type="checkbox"/> no	Child wear's hearing aid?	<input type="checkbox"/> yes <input type="checkbox"/> no
Tested with glasses?	<input type="checkbox"/> yes <input type="checkbox"/> no	Tested with hearing aid?	<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	<input type="checkbox"/> done	<input type="checkbox"/> Child has no discernible speech problem
Child has possible problem with:	<input type="checkbox"/> Articulation	<input type="checkbox"/> Rhythm
	<input type="checkbox"/> Voice	<input type="checkbox"/> Language
Speech evaluation recommended:	<input type="checkbox"/> yes	<input type="checkbox"/> no

Laboratory Tests

<input type="checkbox"/> Hematocrit/Hemoglobin	<input type="checkbox"/> Urine Protein	<input type="checkbox"/> Urine Blood	<input type="checkbox"/> Urine glucose	<input type="checkbox"/> Other
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Physical Examination

Date Examined			
<input type="checkbox"/> Essentially Normal			
Abnormalities as follows: _____			

Is the child able to participate in the following			
A. Classroom and academic activities?	<input type="checkbox"/> yes <input type="checkbox"/> no	C. Competition athletics?	<input type="checkbox"/> yes <input type="checkbox"/> no
B. Physical education classes?	<input type="checkbox"/> yes <input type="checkbox"/> no	D. Contact and collision sports?	<input type="checkbox"/> yes <input type="checkbox"/> 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? _____			

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Side 2

Child's Name	Sex	<input type="checkbox"/> Male	<input type="checkbox"/> Female	Age	DOB
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Immunization Record

Type	Date					
DPT	/ /	/ /	/ /	/ /	/ /	/ /
TD	/ /	/ /	/ /	/ /	/ /	/ /
Polio	/ /	/ /	/ /	/ /	/ /	/ /
Measles (Rubeola)	/ /	/ /				
Rubella	/ /	/ /				
Mumps	/ /	/ /				
MMR Combined	/ /	/ /				
Hepatitis B	/ /	/ /	/ /			
Hib	/ /	/ /	/ /			
Varicella	/ /	/ /	/ /			

Physician's Assessment

Problem List	Recommendation for school management
1.	1.
2.	2.
3.	3.

Please print or stamp

Physician's Name	Physician's Signature
Address	
Phone	Date Signed