INDIAN VALLEY LOCAL SCHOOLS
OHIO SCHOOL HEALTH RECORD
PHYSICIAN'S REPORT

Child's Name________________________________ Male_________ Female________Age__________ Date_________________

OBJECTIVE DATA:

Height:____________(%) Weight:____________(%) BMI:__________ B.P.____/_______

SCREENING TESTS

Vision Date done_____________
Distance Acuity: R______ L___________
Muscle Balance pass____ fail____ not done______
Farsightedness pass____ fail____ not done______
Color pass____ fail____ not done______
Child wear glasses? yes_____ no_____
Tested with glasses? yes_____ no_____
Referral made? yes_____ no_____

Hearing Date Done_____________
Audiometric thresholds:
R - ear pass____ fail____ not done______
L - 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:
Disorders: (check) 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____
B. Physical education classes? yes_____ no____
C. Competitive athletics? 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?

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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________________________

Child's Name ________________________ DOB ________________________

IMMUNIZATION RECORD

Type	Date					
DTaP/DTP/DT	/ /	/ /	/ /	/ /	/ /	
Tdap/Td	/ /	/ /	/ /	/ /	/ /	
Polio (IPV)	/ /	/ /	/ /	/ /	/ /	
MMR	/ /	/ /				
Measles (Rubeola)	/ /	/ /				
Rubella	/ /	/ /				
Mumps	/ /	/ /				
Hepatitis B	/ /	/ /	/ /			
Varicella	/ /	/ /				
HIB (Prior to age 5 only	/ /	/ /	/ /	/ /	/ /	
Other (Identify)	/ /	/ /	/ /	/ /	/ /	/ /