Oakwood Schools 20 Rubicon Road | Oakwood, Ohio 45409 | 937-297-5332 | oakwoodschools.org

Grade: ______ Date of Birth ______________

Child's Name _________________________ Male_____ Female_____ Age_____ Date__________________

OBJECTIVE DATA: Height_________(_______%) Weight__________(_________%) Blood Pressure_________

SCREENING TESTS: Vision Date done ___________ **Hearing** Date done _____________

Distance Acuity	Right______	Left______		Audiometric thresholds:			
Muscle Balance	pass____	fail____	not done____	R ear	pass____	fail ____	not done ____
Farsightedness	pass____	fail____	not done____	L ear	pass____	fail ____	not done ____
Color	pass____	fail____	not done____	Other tests (specify)_________________			

Child wears glasses?	yes____	no____	Child wears hearing aid?	yes____	no____
Tested with glasses?	yes____	no____	Tested with hearing aid?	yes____	no____
Referral made?	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_____

Recommended New Screening as of (2008) **Hematocrit** ______________

- ☐ **Physician does not agree to test**
- ☐ **Reason given** _____________________________

Recommended New Screening as of (2008) **Lead** ___________________

- ☐ **Physician does not agree to test**
- ☐ **High risk area does not exist**
- ☐ **Reason given** _____________________________

Optional Tests:
Urine Protein _______ Urine blood _______ Urine glucose ________

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:

Grade ______________

Child's full name ____
Last First Middle

If this child has any physical, developmental or behavioral problems, how can the school assist with special programs, placement or attention?

____

____

PHYSICIAN'S ASSESSMENT

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

PLEASE PRINT OR STAMP

Physician's name________________________________ Signature ____

Address____
Phone ____ Date ______________________________________

IMMUNIZATION RECORD
COMPLETE DATES (MONTH, DAY, YEAR)

TYPE						
DTP						
POLIO						
HIB						
HEPATITIS B						
VARICELLA						
MMR						
PCV						
OTHER						