Old Trail School

STATE REQUIRED PHYSICIAN REPORT

Student Information:

Student's Name: _____ **Date of Birth:** _____

Current Grade: _____ **Gender:** _____

Date physical exam was completed (required): _____

Physical Examination:

Height: _____Weight: _____ B.P. _____ Pulse: _____ Essentially Normal exam ☐

Abnormalities as follows: _____

Is child able to participate in any/all of the following? Classroom and academic activities? Yes ☐ No ☐

Physical education classes Yes ☐ No ☐ Competitive athletics? Yes ☐ No ☐ Contact or collision sports Yes ☐ No ☐

If limitations please explain _____

Does the student have any developmental, physical or behavioral issues that may affect his/her educational process?

_____

Health History (Chronic issues/health concerns) _____

_____

Preschool requirement for all children under age 6

Hemoglobin/Hematocrit Date: _____ Results: _____

Lead levels

Date: _____ Results: _____

Vision:

Distance Acuity: Right_____Left_____

Tested with glasses? Yes ☐ No ☐

Muscle Balance: Pass ☐ Fail ☐ Not done ☐

Farsightedness: Pass ☐ Fail ☐ Not done ☐

Color vision: Yes ☐ No ☐ Not done ☐

Child wears glasses? Yes ☐ No ☐

Glasses for: All times ☐ Reading ☐ Distance ☐

Referral made? Yes ☐ No ☐

Hearing & Speech:

Pure Tone testing (20 dB @ 1000, 2000, 4000 Hz)

Right Ear: Pass ☐ Fail ☐ Left Ear: Pass ☐ Fail ☐

Other tests (specify): _____

Child wears hearing aid? Yes ☐ No ☐

Tested with Hearing aid? Yes ☐ No ☐

Referral made? Yes ☐ No ☐

Speech Assessment completed? Yes ☐ No ☐

Speech Eval recommended Yes ☐ No ☐

Child has no discernible speech issue

Yes ☐ No ☐

Child has a problem with _____

Medications:

Is the student currently taking any medications: **Yes** ☐ **No** ☐

Please list medications/reason for taking: _____

_____

Will these medications need to be given at school? ___Yes ___No

Immunization Report:

Students are required to be immunized in accordance with Ohio law (Ohio Revised Code 3313.67/3313.671). A copy of the child's immunization record may be attached or dates may be entered below. Please note the month, day, and year for each immunization.

Vaccine	1st Dose	2nd Dose	3rd Dose	4th Dose	5th Dose
Dtap (5 doses required)					
Polio (4 doses required)					
MMR (2 doses required)					
Varicella (Chicken Pox) (2 doses required)					
Hepatitis B (3 doses required)					
HIB (Preschool requirement)					
Hepatitis A (Preschool requirement)					
Pneumococcal (Preschool requirement)					
Annual Flu Shot (Required for Preschool)					
Tdap (7th grade requirement)					
Meningococcal (7th grade requirement)					

Signature (required): _____ **Date:** _____

Printed Physician's Name: _____

Address & Phone: _____

*If exempt from vaccinations, please request a waiver form from the school clinic. Waivers are required for any missing vaccinations and must be updated every school year.