

NORWOOD CITY SCHOOL DISTRICT

Pre-School

Ohio School History Physician Assessment

Name: _____ Gender: _____ Age: _____ DOB: _____

Ethnicity: Caucasian African American Hispanic Asian American Other

Objective Data:

Height _____ Weight: _____ B.P.: _____

IMMUNIZATION Required for school entry						
TYPE	DATE: MO/DAY/YEAR					
DtaP, DPT or DT						5 th dose required if 4 th dose given before 4 th b-day for Kindergarten
DT/Td						Grades 1-12* : 4 doses of DtaP, DTP, DT or Td or any combination Grade 7-12: 1 dose of Tdap or Td prior to entry
POLIO						K-11 students must have 3 or more doses of IPV, final dose on or after 4 th bday; 4 doses if a combination of OPV/IPV. Grades 12 4 doses if combination IPV/OPV. 4 doses if all IPV/OPV & if the final dose was given before 4 th birthday
MMR						KG-12 : 2 doses required for 2024-25
HEPATITIS B						K-12 : 3 doses required for 2024-25
VARICELLA						K-11 must have 2 doses for 2024-25 Gr 12 must have 1 dose for 2024-25
HIB (prior to age 5 only)						0-14 months; 3-4 doses, 5-59 months; 1 dose
TUBERCULIN TEST						Required if traveled to high-risk area
ROTAVIRUS (given @ 2-4-6 mo. Not after 12 mos.)						
MCV4						Gr 7-11 must have 1 dose for 2024-25 Gr 12 must have 2 doses for 2024-25

SCREENING TESTS

Vision: _____ Date: _____ Distance Acuity Right _____ Left _____ Muscle Balance <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 Color <input type="checkbox"/> Pass <input type="checkbox"/> Fail <input type="checkbox"/> Not Done 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 Specify Test/Equipment: _____	Hearing: _____ Date: _____ Pure Tone Testing: Right Ear <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 Child Wears Hearing Aid? <input type="checkbox"/> Yes <input type="checkbox"/> No Testing With Hearing Aid? <input type="checkbox"/> Yes <input type="checkbox"/> No Referral Made? <input type="checkbox"/> Yes <input type="checkbox"/> No Other Test(specify): _____
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SPEECH ASSESSMENT Date: _____ <input type="checkbox"/> Child has no discernable speech problem <input type="checkbox"/> Child has possible problem with: <input type="checkbox"/> Articulation <input type="checkbox"/> Rhythm <input type="checkbox"/> Voice <input type="checkbox"/> Language Speech evaluation is recommended: <input type="checkbox"/> Yes <input type="checkbox"/> No

Physician Assessment (CONTINUED)

LABORATORY TESTS

**ODH Lead Testing Requirement: ages 6-72 months

- Hemoglobin/Hematocrit Urine Protein Urine Blood Urine Glucose
 **BLL (Blood Lead Level):

PHYSICAL EXAMINATION

**Preschool students must have a signed physician exam on file with the school within 30 days of admission, renewed every year while in Preschool. The exam must have been given within the year.

Date of Examination: _____

- This child is essentially within normal limits
 This child is not within normal limits

Explain:

Does this child have any physical, developmental or behavioral problems? Suggest special programs, placement or attention that the school can provide.

ACTIVITIES & LIMITATIONS

Can the child participate fully in the following activities?

- Classroom and academic activities Yes No
Physical Education classes Yes No
Competitive Athletics Yes No
Contact & Collision Sports Yes No

Specify any limitations:

Is this child on any medications? Yes No

Explain:

Examiner's Signature: _____ Date signed: _____

Examiner's Printed Name: _____

Address: _____

Phone: _____