

# Old Trail School

## State-Required Physician Report for EC-K Students

Student Name: \_\_\_\_\_ Gender: \_\_\_\_\_ DOB: \_\_\_\_\_ Grade: \_\_\_\_\_

**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 and 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

\*\*\*Additional forms are needed for medications to be given at school\*\*\*

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

<b>Signature:(REQUIRED)</b>	Printed Physician's Name
<b>Date:</b>	Address and 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.**