

OHIO SCHOOL HEALTH FORM
Physician's Report

School _____
 Date Enrolled _____ Gr _____

Student's Legal Last Name	First Name	Middle Name

Date of Physical Examination: _____ Today's Date _____

Vision		Hearing	
Distance Acuity	Date	Pure tone testing:	Date
Right _____	Left _____	Right ear <input type="checkbox"/> Pass <input type="checkbox"/> Fail <input type="checkbox"/> Not done	
Muscle Balance <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	
Stereopsis <input type="checkbox"/> Pass <input type="checkbox"/> Fail <input type="checkbox"/> Not done		Student wears hearing aid? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Color <input type="checkbox"/> Pass <input type="checkbox"/> Fail <input type="checkbox"/> Not done		Testing with hearing aid? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Student wears glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No		Referral Made? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Tested with glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No		Other Test (specify)	
Referral Made? <input type="checkbox"/> Yes <input type="checkbox"/> No			

Speech Assessment Date: _____

Student has no discernible speech problem

Student has possible problem with: Articulation Rhythm Voice Language

Speech evaluation is recommended: Yes No

Objective Data

Height	Weight	BP

Laboratory Tests:

Hemoglobin/Hematocrit Urine Protein Urine Blood Urine glucose

Other: _____

Physical Exam:

Physical Exam essentially within normal limits.

Physical Exam is not within normal limits.

Explain: _____

Does this student have any physical, developmental, or behavioral problems? Yes No

If yes, please suggest special programs, placement or attention that the school can provide.

Activities & Limitations:

Can the student participate fully in the following activities?

Classroom and academic activities?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Physical Education classes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Competitive Athletics	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Contact and collision sports	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Medications: Is this student on any medications? Yes No

Explain: _____

Immunizations given at this examination _____

Physician's Signature: _____ Date signed _____

Physician's Printed Name: _____

Address: _____ Phone No: _____