

# Physical Examination

Student's Name		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth / /
Height	Weight	BMI percentile	BP

## Screening Tests

Vision	Hearing	Postural
Date performed / /	Date performed / /	Date performed / /
Distance Acuity <input type="checkbox"/> R <input type="checkbox"/> L Muscle Balance <input type="checkbox"/> Pass <input type="checkbox"/> Fail Stereopsis <input type="checkbox"/> Pass <input type="checkbox"/> Fail Color <input type="checkbox"/> Pass <input type="checkbox"/> Fail 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	Pure Tone Right ear <input type="checkbox"/> Pass <input type="checkbox"/> Fail Left ear <input type="checkbox"/> Pass <input type="checkbox"/> Fail Child wears hearing aid? <input type="checkbox"/> Yes <input type="checkbox"/> No Child under the care of a hearing specialist <input type="checkbox"/> Yes <input type="checkbox"/> No Referral made? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> No abnormality noted <input type="checkbox"/> Screening not done <input type="checkbox"/> Referral made Comments _____ _____ _____

## Speech/Language

Speech assessment completed  
 Child has no discernible speech problem  
 Speech evaluation recommended  
 Child has possible problem with \_\_\_\_\_

## Lead Poisoning

Date \_\_\_\_\_ Type  C  V Results \_\_\_\_\_ pg/dL  
 Date \_\_\_\_\_ Type  C  V Results \_\_\_\_\_ pg/dL

## Hematocrit

Date \_\_\_\_\_ Result \_\_\_\_\_

## Tuberculin Test

Date \_\_\_\_\_ Type \_\_\_\_\_ Results \_\_\_\_\_

## Health History (Serious or chronic illnesses/injuries/surgeries)

_____ _____ _____
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## Physical Examination Date of most recent examination / /

Essentially normal  Abnormalities as follows  
 \_\_\_\_\_  
 \_\_\_\_\_

Is the child able to participate fully in:

Classroom and academic activities	<input type="checkbox"/> Yes <input type="checkbox"/> No	Physical education classes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Competition athletics	<input type="checkbox"/> Yes <input type="checkbox"/> No	Contact and collision sports	<input type="checkbox"/> Yes <input type="checkbox"/> No

If limitations are advised, please specify  
 \_\_\_\_\_  
 \_\_\_\_\_

Does this child have physical, developmental or behavioral issues that may affect his/her educational process?  
 \_\_\_\_\_  
 \_\_\_\_\_

### IMMUNIZATIONS

Type	Date – Must Have Mo/Day/Year					
<b>DTaP/DPT/DT</b> Diphtheria, Tetanus, Pertussis						
<b>DT/Td</b>						
<b>POLIO</b>						
<b>MMR</b> Measles, Mumps, Rubella						
<b>HEPATITIS B</b>						
<b>VARICELLA*</b> Chickenpox						
<b>HIB (Preschool)</b>						
<b>OTHER</b>						

\*Please indicate with a **D** – disease and date (year only) if your child has already had the Chickenpox.

HealthCare Provider's signature	Print name	Phone (     )
Address		Date /    /
City	State	Zip

**Must be returned by the start of the first day of school. Thank you!**

# Ohio Department of Health • School and Adolescent Health

## Oral Assessment

Student's name	Date of birth / /
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The following services have been performed (please check all that apply)

<input type="checkbox"/> Examination	<input type="checkbox"/> Fluoride application	<input type="checkbox"/> Oral prophylaxis (cleaning)	<input type="checkbox"/> Prescription for fluoride supplement
<input type="checkbox"/> Orthodontic assessment	<input type="checkbox"/> Radiographs	<input type="checkbox"/> Dental sealant	<input type="checkbox"/> Treatment (restoration, pulp therapy)
<input type="checkbox"/> Other _____			

The following oral hygiene instruction was provided (please check all that apply)

<input type="checkbox"/> Toothbrushing	<input type="checkbox"/> Flossing	<input type="checkbox"/> Dietary counseling	<input type="checkbox"/> Use of fluoride mouthrinse
<input type="checkbox"/> Other _____			

The following statements are applicable (please check all that apply)

<input type="checkbox"/> All necessary preventive services have been performed. (Fluoride treatment, prophylaxis)
<input type="checkbox"/> No restorative services are required at this time.
<input type="checkbox"/> Further treatment is indicated. (See comments)
<input type="checkbox"/> Further appointments have been arranged. (Orthodontic, restorative)
<input type="checkbox"/> Routine recall visits recommended.

Comments

Dentist's signature	Print name	Phone (   )
Address		Date / /
City	State	ZIP



# Health History continued

Please list any prescription and over the counter medication that your child takes on a regular basis.

Medication and dose	Time	Reason

Do any health and/or medical conditions require school restrictions, modifications, and/or intervention?

Yes    No   If YES, please explain.

Does the student require any special procedures and/or treatments for their health condition(s)?

Yes    No   If YES, please explain.

Please indicate any other information about your child's health or development that you think would be helpful for the school to know.

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Form completed by	Relationship to student	Date / /
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