Physician to complete

Ohio Department of Health • School and Adolescent Health

Physical Examination

Student's name	Sex ☐ Male ☐ Female	Date of birth / /

Height	Weight	BMI percentile	BP

Screening Tests

Vision

Date performed / /

Distance Acuity	☐ R	☐ L
Muscle Balance	☐ Pass	☐ Fail
Stereopsis	☐ Pass	☐ Fail
Color	☐ Pass	☐ Fail
Child wears glasses?	☐ Yes	☐ No
Tested with glasses?	☐ Yes	☐ No
Referral made?	☐ Yes	☐ No

Hearing

Date performed / /

Pure Tone		
Right ear	☐ Pass	☐ Fail
Left ear	☐ Pass	☐ Fail
Child wears hearing aid?	☐ Yes	☐ No
Child under the care of a hearing specialist	☐ Yes	☐ No
Referral made?	☐ Yes	☐ No

Postural

Date performed / /

☐ No abnormality noted
☐ Screening not done
☐ Referral made
Comments ______

Speech/Language

Speech assessment completed	☐ Yes	☐ No
Child has no discernible speech problem	☐ Yes	☐ No
Speech evaluation recommended	☐ Yes	☐ No
Child has possible problem with ______		

Lead Poisoning

☐ Date ______ Type ☐ C ☐ V Results______ µg/dL
☐ Date ______ Type ☐ C ☐ V Results______ µg/dL

Tuberculin Test

Date______ Type ______ Results______

Hemoglobin Test Date: ______ Results ______

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

______

Physical Examination Date of most recent examination / /

☐ Essentially normal ☐ Abnormalities as follows

______

Is this child able to participate fully in:

Classroom and academic activities	☐ Yes	☐ No	Physical education classes	☐ Yes	☐ No
Competition athletics	☐ Yes	☐ No	Contact and collision sports	☐ Yes	☐ No

If limitations are advised, please specify

______

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

______

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

HEA 4242 8/06

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Immunization

Student ______________________________ **Birthdate**____________________

Ohio Law – Areas Required Must be Completed for School Entry

Type	Date-Month/Day/Year					
DtAP. DPT or DT	Required	Required	Required	Required	Required	5th dose required if 4th dose given before age 5
DT/Td						
Polio	Required	Required	Required	Required	4th dose requied if 3rd dose given before age 4	
Measles. Mumps. Rubella (MMR)	Required	Required				
Hib-Hemophilus Inflluenzae B (prior to age 5 only)				0-14 mos. 3-4 doses 15-59 mos. 1 dose		
Hepatitis B	Required	Required	Required			
Varicella	Required					
Tuberculin Test						
Rotavirus (given at 2-4-6 mos.. not after 12 mos.)						
Other						

Verified by ______________________________ **Date** ____________________________