

SCHOOL: \_\_\_\_\_

DATE: \_\_\_\_\_

Ohio Department of Health • School and Adolescent Health

# 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**

**Lead Poisoning**

Speech assessment completed <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Date _____ Type <input type="checkbox"/> C <input type="checkbox"/> V Results _____ µg/dL
Child has no discernible speech problem <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Date _____ Type <input type="checkbox"/> C <input type="checkbox"/> V Results _____ µg/dL
Speech evaluation recommended <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Tuberculin Test</b> Date _____ Type _____ Results _____
Child has possible problem with _____	

**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 <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 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