PHYSICAL EXAMINATION

Student Name	Sex □ Male □ Female	Date of Birth ________/________/________
Height	Weight	BMI percentile BP

Screening Tests

Vision	Hearing	Postural
Date performed _______/_______/_______	Date performed _______/_______/_______	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	Pure Tone Right ear □ Pass □ Fail Left ear □ Pass □ Fail Child wears hearing aide? □ Yes □ No Child under the care of a hearing specialist? □ Yes □ No Referral made? □ Yes □ No	□ No abnormality noted □ Screening not done □ Referral made Comments ___________________ ____________________________ ____________________________ ____________________________

HGB Results __________
PRESCHOOL ONLY

Speech/Language	Lead Poisoning
Speech assessment completed □ Yes □ No Child has no discernible speech problem □ Yes □ No Speech evaluation recommended □ Yes □ No Child has possible problem with __________________ ____	□ Date_________________ Type □ C □ V Results _________pg/dL □ Date_________________ Type □ C □ V Results _________pg/dL ____ Tuberculin Test Date _________________ Type ___________ 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?
____
____

Health Care Provider's signature	Print name	Phone ( )
Address		Date _______/_______/_______
City	State	Zip

(over)

Ohio Department of Health • School and Adolescent Health

Immunization Report

Student name	Sex ☐ Male ☐ Female	Date of birth _______/_______/_______

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 should be on record.

Vaccine	**Record complete dates** (month, day, year) **of vaccine doses given**					
Diphtheria, Tetanus, Pertussis (DTP)						
DTaP, Tdap						
DT, Td						
Polio						
Hepatitis B (HBV)						
Measles, Mumps, Rubella (MMR)						
Varicella (Chickenpox)						
Hepatitis A						
Meningococcal (MCV4, MPSV4)						
Pneumococcal (PCV)						
Measles (Rubeola) only						
Rubella only						
Mumps only						
Haemophilus influenza Type B (Hib)						
Influenza						
Other						

This information was provided by ☐ Health Care Provider ☐ Parent/Guardian ☐ Other _____________________________

Signature	Print name	Date _______/_______/_______

Oral Assessment

Student name	Sex ☐ Male ☐ Female	Date of birth _______/_______/_______

The following services have been performed (please check all that apply)

☐ Examination ☐ Fluoride application ☐ Oral prophylaxis (cleaning) ☐ Prescription for fluoride supplement
☐ Orthodontic assessment ☐ Radiographs ☐ Dental sealant ☐ Treatment (restoration, pulp therapy)
☐ Other ____

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

☐ Tooth brushing ☐ Flossing ☐ Dietary counseling ☐ Use of fluoride mouth rinse
☐ Other
____

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

☐ All necessary preventive services have been performed. (Fluoride treatment, prophylaxis)
☐ No restorative services are required at this time.
☐ Further treatment is indicated. (See comments)
☐ Further appointments have been arranged. (Orthodontic, restorative)
☐ Routine recall visits recommended.
____
Comments
____
____
____
____

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