

Ohio School Health Record Physician's Report

Child's Name _____ Male ___ Female ___ Date _____

OBJECTIVE DATA

Height _____ (%) Weight _____ (%) B/P _____ / _____

SCREENING TEST

Date performed _____

Vision	Hearing
Distance Acuity R _____ L _____	Audiometric thresholds:
Muscle Balance <input type="checkbox"/> pass <input type="checkbox"/> fail <input type="checkbox"/> n/a	R – ear <input type="checkbox"/> pass <input type="checkbox"/> fail <input type="checkbox"/> n/a
Farsightedness <input type="checkbox"/> pass <input type="checkbox"/> fail <input type="checkbox"/> n/a	L – ear <input type="checkbox"/> pass <input type="checkbox"/> fail <input type="checkbox"/> n/a
Color <input type="checkbox"/> pass <input type="checkbox"/> fail <input type="checkbox"/> n/a	Other tests (specify) _____
Child wears glasses <input type="checkbox"/> yes <input type="checkbox"/> no	Child wears hearing aid? <input type="checkbox"/> yes <input type="checkbox"/> no
Tested with glasses <input type="checkbox"/> yes <input type="checkbox"/> no	Tested with hearing aid? <input type="checkbox"/> yes <input type="checkbox"/> no
Referral made? <input type="checkbox"/> yes <input type="checkbox"/> no	Referral made? <input type="checkbox"/> yes <input type="checkbox"/> no

SPEECH / LANGUAGE

Speech assessment <input type="checkbox"/> done <input type="checkbox"/> not done <input type="checkbox"/> Child has no discernible speech problem
Child has possible problem with <input type="checkbox"/> Articulation <input type="checkbox"/> Rhythm <input type="checkbox"/> Voice <input type="checkbox"/> Language
Speech evaluation recommended <input type="checkbox"/> yes <input type="checkbox"/> no

LABORATORY TESTS

<input type="checkbox"/> Hematocrit/Hemoglobin <input type="checkbox"/> Urine protein <input type="checkbox"/> Urine blood <input type="checkbox"/> Urine glucose <input type="checkbox"/> Other _____

PHYSICAL EXAMINATION

Date Examined _____ Essentially Normal <input type="checkbox"/> yes <input type="checkbox"/> no
Abnormalities as follows _____ _____ _____
Is this child able to participate fully in the following? A. Classroom and academic activities? <input type="checkbox"/> yes <input type="checkbox"/> no B. Physical education classes? <input type="checkbox"/> yes <input type="checkbox"/> no C. Competitive athletics? <input type="checkbox"/> yes <input type="checkbox"/> no D. Contact and collision sports? <input type="checkbox"/> yes <input type="checkbox"/> no
If limitations are advised, please specify those limitations _____ _____ _____
If this child has any physical, developmental or behavioral problems, how can the school assist with special programs, placement or attention? _____ _____ _____

PHYSICIAN'S ASSESSMENT

Problem List	Recommendation for school management
1.	1.
2.	2.
3.	3.

IMMUNIZATION RECORD

Vaccine	Record complete dates of vaccine doses given (month, day & year)					
Diphtheria, Tetanus, Pertussis						
Dtap, Tdap						
Polio						
Measles, Mumps, Rubella						
Haemophilus influenza Type b						
Hepatitis B (HBV)						
Hepatitis A						
Varicella						
Meningococcal (MCV4,MPSV4)						
Other						

Verification completed by _____ Date _____

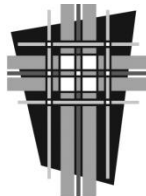
PLEASE PRINT OR STAMP

Physician's name _____ Physician's signature _____

Address _____

Phone _____ Date signed _____

Please return to



ST. ANTHONY
SCHOOL

1300 Urban Drive • Columbus, Ohio 43229
p. 614-888-4268 • f. 614-888-4435

**-OVER-
PLEASE COMPLETE BOTH SIDES**