

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 (R) 20 / (L) 20 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	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Child has no discernible speech problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Speech evaluation recommended	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Child has possible problem with _____		

Lead Poisoning

<input type="checkbox"/> Date _____	Type <input type="checkbox"/> C <input type="checkbox"/> V	Results _____ µg/dL
<input type="checkbox"/> Date _____	Type <input type="checkbox"/> C <input type="checkbox"/> V	Results _____ µg/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?

Allergies:

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