

PHYSICAL EXAMINATION

Student 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 aide? <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

HGB Results _____
PRESCHOOL ONLY

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 _____ _____	<input type="checkbox"/> Date _____ Type <input type="checkbox"/> C <input type="checkbox"/> V Results _____ pg/dL <input type="checkbox"/> Date _____ Type <input type="checkbox"/> C <input type="checkbox"/> V Results _____ pg/dL _____ Tuberculin Test Date _____ Type _____ Results _____
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Health History (Serious or chronic illnesses/injuries/surgeries)

Physical Examination Date of most recent examination ____/____/____

<input type="checkbox"/> Essentially normal <input type="checkbox"/> 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? _____ _____ _____

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

(over)

Immunization Report

Student name	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth ____/____/____
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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 ____/____/____
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Oral Assessment

Student name	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth ____/____/____
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The following services have been performed (please check all that apply)

<input type="checkbox"/> Examination	<input type="checkbox"/> Fluoride application	<input type="checkbox"/> Oral prophylaxis (cleaning)	<input type="checkbox"/> Prescription for fluoride supplement
<input type="checkbox"/> Orthodontic assessment	<input type="checkbox"/> Radiographs	<input type="checkbox"/> Dental sealant	<input type="checkbox"/> Treatment (restoration, pulp therapy)
<input type="checkbox"/> Other _____			

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

<input type="checkbox"/> Tooth brushing	<input type="checkbox"/> Flossing	<input type="checkbox"/> Dietary counseling	<input type="checkbox"/> Use of fluoride mouth rinse
<input type="checkbox"/> Other _____			

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

<input type="checkbox"/> All necessary preventive services have been performed. (Fluoride treatment, prophylaxis)
<input type="checkbox"/> No restorative services are required at this time.
<input type="checkbox"/> Further treatment is indicated. (See comments)
<input type="checkbox"/> Further appointments have been arranged. (Orthodontic, restorative)
<input type="checkbox"/> Routine recall visits recommended.
Comments

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