Ohio Department of Health • School and Adolescent Health

Physical Examination

Attach a copy of immunization records listing the month, day, and year of all immunizations .

Student's 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	Pure Tone	☐ No abnormality noted
Muscle Balance ☐ Pass ☐ Fail	Right ear ☐ Pass ☐ Fail	☐ Screening not done
Stereopsis ☐ Pass ☐ Fail	Left ear ☐ Pass ☐ Fail	☐ Referral made
Color ☐ Pass ☐ Fail	Child wears hearing aid? ☐ Yes ☐ No	Comments
Child wears glasses? ☐ Yes ☐ No	Child under the care of a hearing specialist ☐ Yes ☐ No	______
Tested with glasses? ☐ Yes ☐ No		______
Referral made? ☐ Yes ☐ No	Referral made? ☐ Yes ☐ No	______

Speech/Language

Speech assessment completed	☐ Yes	☐ No
Child has no discernible speech problem	☐ Yes	☐ No
Speech evaluation recommended	☐ Yes	☐ No
Child has possible problem with ______		

Lead Poisoning

☐ Date ______ Type ☐ C ☐ V Results______ μg/dL

☐ Date ______ Type ☐ C ☐ 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?

______

______

☐ Child has lactose intolerance. Please provide separate documentation for the food service director.

Food Allergies: Other Allergies:

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

HEA 4242 8/06