

Ohio Department of Health • School and Adolescent Health

Physical Examination (Physician)

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	<input type="checkbox"/> R <input type="checkbox"/> L	Pure Tone		<input type="checkbox"/> No abnormality noted	
Muscle Balance	<input type="checkbox"/> Pass <input type="checkbox"/> Fail	Right ear	<input type="checkbox"/> Pass <input type="checkbox"/> Fail	<input type="checkbox"/> Screening not done	
Stereopsis	<input type="checkbox"/> Pass <input type="checkbox"/> Fail	Left ear	<input type="checkbox"/> Pass <input type="checkbox"/> Fail	<input type="checkbox"/> Referral made	
Color	<input type="checkbox"/> Pass <input type="checkbox"/> Fail	Child wears hearing aid?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comments	
Child wears glasses?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Child under the care of a hearing specialist	<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	_____	
Referral made?	<input type="checkbox"/> Yes <input type="checkbox"/> No			_____	

Speech/Language	Lead Poisoning
Speech assessment completed <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Date _____ Type <input type="checkbox"/> C <input type="checkbox"/> V Results _____ µg/dL
Child has no discernible speech problem <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Date _____ Type <input type="checkbox"/> C <input type="checkbox"/> V Results _____ µg/dL
Speech evaluation recommended <input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculin Test
Child has possible problem with _____	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	<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?

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