Ohio School Health Record
Physician's Report

Child's name	Sex ☐ Male ☐ Female	Age	Date

Objective data

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

Screening Tests

VISION Date

Distance Acuity right ______ left ______

Muscle Balance	☐ pass	☐ fail	☐ not done
Farsightedness	☐ pass	☐ fail	☐ not done
Color	☐ pass	☐ fail	☐ not done
Child wears glasses?	☐ yes	☐ no	
Tested with glasses?	☐ yes	☐ no	
Referral made?	☐ yes	☐ no	

HEARING Date

Pure tone testing:

Right ear	☐ pass	☐ fail	☐ not done
Left ear	☐ pass	☐ fail	☐ not done

Other tests (specify) ______________________

Child wears hearing aid?	☐ yes	☐ no
Tested with hearing aid?	☐ yes	☐ no
Referral made?	☐ yes	☐ no

Speech/Language

Speech assessment: ☐ done ☐ not done ☐ Child has no discernible speech problem

Child has possible problem with: ☐ Articulation ☐ Rhythm ☐ Voice ☐ Language

Speech evaluation recommended: ☐ yes ☐ No

Laboratory Tests

☐ Hematocrit/Hemoglobin ☐ Urine protein ☐ Urine blood ☐ Urine glucose ☐ Other:

Physical Examination:

Date examined

☐ Essentially normal Abnormalities as follows: ______________________

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Is this child able to participate fully in the following:

A. Classroom and academic activities? ☐ yes ☐ no

B. Physical education classes? ☐ yes ☐ no

C. Competition athletics? ☐ yes ☐ no

D. Contact and collision sports? ☐ yes ☐ no

If limitations are advised, please specify those limitations: ______________________

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If this child has any physical, developmental or behavioral problems, how can the school assist with special programs, placement or attention?

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Physician's Assessment

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

PLEASE PRINT OR STAMP

Physician's name	Physician's signature
Address	
Phone	Date signed