

# Ohio School Health Record Physician's Report



## Northmont City Schools

4001 Old Salem Road  
Englewood, Ohio 45322

167,000  
02/04  
Side 1

Child's Name	Sex	<input type="checkbox"/> Male	<input type="checkbox"/> Female	Age	DOB
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### Objective Data

Height	(	%)	Weight	(	%)	B.P.	/
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### Screening Tests

Vision	Date	Hearing	Date
Distance Acuity	right _____ left _____	Pure tone testing	
Muscle Balance	<input type="checkbox"/> pass <input type="checkbox"/> fail <input type="checkbox"/> not done	Right ear	<input type="checkbox"/> pass <input type="checkbox"/> fail <input type="checkbox"/> not done
Farsightedness	<input type="checkbox"/> pass <input type="checkbox"/> fail <input type="checkbox"/> not done	Left ear	<input type="checkbox"/> pass <input type="checkbox"/> fail <input type="checkbox"/> not done
Color	<input type="checkbox"/> pass <input type="checkbox"/> fail <input type="checkbox"/> not done	Other tests (specify) _____	
Child wear's glasses?	<input type="checkbox"/> yes <input type="checkbox"/> no	Child wear's hearing aid?	<input type="checkbox"/> yes <input type="checkbox"/> no
Tested with glasses?	<input type="checkbox"/> yes <input type="checkbox"/> no	Tested with hearing aid?	<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

Speech Assessment	<input type="checkbox"/> done	<input type="checkbox"/> Child has no discernible speech problem
Child has possible problem with:	<input type="checkbox"/> Articulation	<input type="checkbox"/> Rhythm
	<input type="checkbox"/> Voice	<input type="checkbox"/> Language
Speech evaluation recommended:	<input type="checkbox"/> yes	<input type="checkbox"/> no

### Laboratory Tests

<input type="checkbox"/> Hematocrit/Hemoglobin	<input type="checkbox"/> Urine Protein	<input type="checkbox"/> Urine Blood	<input type="checkbox"/> Urine glucose	<input type="checkbox"/> Other
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### Physical Examination

Date Examined	
<input type="checkbox"/> Essentially Normal	
Abnormalities as follows: _____	
_____	
_____	
Is the child able to participate in the following	
A. Classroom and academic activities?	<input type="checkbox"/> yes <input type="checkbox"/> no
B. Physical education classes?	<input type="checkbox"/> yes <input type="checkbox"/> no
C. Competition athletics?	<input type="checkbox"/> yes <input type="checkbox"/> no
D. Contact and collision sports?	<input type="checkbox"/> yes <input type="checkbox"/> no
If limitations are advised, please specify those limitations: _____	
_____	
_____	
If this child has any physical, developmental or behavioral problems, how can the school assist with special programs, placement or attention? _____	
_____	
_____	

# Ohio School Health Record Physician's Report

167,000  
02/04  
Side 2

Child's Name	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Age	DOB
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## Immunization Record

Type	Date							
DPT	/ /	/ /	/ /	/ /	/ /	/ /		
TD	/ /	/ /	/ /	/ /	/ /	/ /		
Polio	/ /	/ /	/ /	/ /	/ /	/ /		
Measles (Rubeola)	/ /	/ /						
Rubella	/ /	/ /						
Mumps	/ /	/ /						
MMR Combined	/ /	/ /						
Hepatitis B	/ /	/ /					/ /	
Hib	/ /	/ /					/ /	/ /
Varicella	/ /	/ /						

## 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