Ohio Department of Health

Physical Examination

Student's name	Sex ☐ Male ☐ Female	Date of birth / /

Height	Weight	BMI percentile	BP

Screening Tests

Vision	Hearing	Postural
SEE ATTACHED FORM	SEE ATTACHED FORM	Date performed / /
		☐ No abnormality noted ☐ Screening not done ☐ Referral made Comments _____

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?

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

Form: K

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Screening Results Documentation Form

Form to be Completed by Healthcare Provider

Name:	School Year:

I authorize my child's physician to release this completed form to _____. Please fax to _____,

Attention: _____ I understand that the requestor will protect this information as prescribed by the Family Educational Rights and Privacy Act (FERPA) and the Health Privacy Act (including HIPPA).

_____ _____

Parent/Guardian Signature Date

Childs' Name _____ Date of Birth _____

Pure Tone Hearing Screening Results

	1000	2000	4000	Observation/Comments:
R	Pass_____ (20 dB)	Pass_____ (20 dB)	Pass_____ (20 dB)	
	Non Pass_____	Non Pass_____	Not Pass_____	
L	Pass_____ (20 dB)	Pass_____ (20 dB)	Pass_____ (20 dB)	
	Non Pass_____	Non Pass_____	Not Pass_____	

EVALUATION RESULTS:

Diagnosis: _____

Treatment Plan: _____

Comments: _____

Vision Screening Results

Acuity Test:	Uncorrected:	Corrected:	Indicate Type by placing a :"X"	Electronic Screener (circle one):	Observation/ Comments:
R	Pass:	Pass:	_____ Lea 5 ft. _____ Lea 10 ft. _____ Eye Check _____ Sloan Chart 10 ft	Suresight/Retinomax/JVAS	
	Non Pass_____	Non Pass_____			
L	Pass:	Pass:	_____ Lea 5 ft. _____ Lea 10 ft. _____ Eye Check _____ Sloan Chart 10 ft	Suresight/Retinomax/JVAS	
	Non Pass_____	Non Pass_____			
Stereopsis	Pass	Fail	_____Smile (PASS 2) _____Random Dot E		
Color Vision (Male Only)	Pass	Non Pass	____ Ishihara - 14 plate ____ Pseudoisochromatic color testing - 16 plate ____ Color Vision Testing Made Easy		

EVALUATION RESULTS:

Diagnosis: _____

Treatment Plan: _____

Comments: _____

Signature of examining Healthcare Provider:	Date of exam:
_____	
Address: _____	
Phone: _____	

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Oral Assessment

Student's name	Date of birth
	/ /

The following services have been performed (please check all that apply)

☐ Examination ☐ Fluoride application ☐ Oral prophylaxis (cleaning) ☐ Prescription for fluoride supplement
☐ Orthodontic assessment ☐ Radiographs ☐ Dental sealant ☐ Treatment (restoration, pulp therapy)
☐ Other_____

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

☐ Toothbrushing ☐ Flossing ☐ Dietary counseling ☐ Use of fluoride mouthrinse
☐ Other_____

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

☐ All necessary preventive services have been performed. (Fluoride treatment, prophylaxis)
☐ No restorative services are required at this time.
☐ Further treatment is indicated.(See comments)
☐ Further appointments have been arranged. (Orthodontic, restorative)
☐ Routine recall visits recommended.

Comments

_____

_____

_____

_____

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

Ohio
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School and Adolescent Health

Immunization Report

Student's Name	Sex	Date of Birth
	☐ Male ☐ Female	/ /

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 (DTap,DT, Tdap, Td)	
Polio	
Hepatitis B (HBV)	
Measles, Mumps, Rubella (MMR)	
Varicella (Chicken pox)	
Hepatitis A	
Meningococcal (MCV4)	
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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