

**School Health Record**

**Physician's Report**

School Holy Family School  
 FAX 330-688-3474

Child's name	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Age	Date
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**Objective data**

Height ( %)	Weight ( %)	B.P. /	Pulse
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**Screening Tests**

VISION		Date		HEARING		Date	
Distance Acuity	right _____ left _____	Pure tone testing (20 dB @ 1000, 2000, 4000 Hz)					
Tested with glasses?	<input type="checkbox"/> yes <input type="checkbox"/> no	Right ear	<input type="checkbox"/> pass	<input type="checkbox"/> fail	<input type="checkbox"/> not done		
Muscle Balance	<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		
Farsightedness	<input type="checkbox"/> pass <input type="checkbox"/> fail <input type="checkbox"/> not done	Other tests (specify) _____					
Random Dot E	<input type="checkbox"/> pass <input type="checkbox"/> fail <input type="checkbox"/> not done	Child wears hearing aid? <input type="checkbox"/> yes <input type="checkbox"/> no					
Color vision with pseudo-isochromatic plates	<input type="checkbox"/> pass <input type="checkbox"/> fail <input type="checkbox"/> not done	Tested with Hearing aid? <input type="checkbox"/> yes <input type="checkbox"/> no					
Child wears glasses?	<input type="checkbox"/> yes <input type="checkbox"/> no	Referral made? <input type="checkbox"/> yes <input type="checkbox"/> no					
Glasses worn for:	<input type="checkbox"/> distance <input type="checkbox"/> reading <input type="checkbox"/> at all times						
Referral made?	<input type="checkbox"/> yes <input type="checkbox"/> no						

**Speech/Language**

Speech assessment:	<input type="checkbox"/> done	<input type="checkbox"/> not 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 this child able to participate fully in the following:

A. Classroom and academic activities?	<input type="checkbox"/> yes <input type="checkbox"/> no	C. Competitive athletics?	<input type="checkbox"/> yes <input type="checkbox"/> no
B. Physical education classes?	<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?

_____
_____
_____

# School Health Record

## Medications:

If this child is taking any medication, please list medication and reason for taking:

Medication	Reason for taking

## Immunizations: Ohio Law describes minimum requirements for school entrance.

Type:	Record Month/Day/Year
DTaP, DPT, DT	_____
Td, TDaP	_____
Polio, OPV, IPV	_____
MMR	_____
Hepatitis B	_____
Varivax (chickenpox)	_____ (date of vaccine or disease)
HIB	_____
Pevnar (pneumococcal)	_____ Recommended.
TB Test	_____ Result: Neg. _____ or Pos. _____ Optional
Other	_____

## Please print or stamp:

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