

**Ohio Department of Health • School and Adolescent Health**

# Physical Examination

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

**Speech/Language**

Speech assessment completed	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child has no discernible speech problem	<input type="checkbox"/> Yes <input type="checkbox"/> No
Speech evaluation recommended	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child has possible problem with _____	

**Lead Poisoning**

<input type="checkbox"/> Date _____ Type <input type="checkbox"/> C <input type="checkbox"/> V Results _____ µg/dL
<input type="checkbox"/> Date _____ Type <input type="checkbox"/> C <input type="checkbox"/> V Results _____ µg/dL
<b>Tuberculin Test</b> Date _____ Type _____ Results _____

**Health History** (Serious or chronic illnesses/injuries/surgeries)

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**Physical Examination** Date of most recent examination / /

<input type="checkbox"/> Essentially normal	<input type="checkbox"/> Abnormalities as follows
Is this child able to participate fully in:	
Classroom and academic activities	<input type="checkbox"/> Yes <input type="checkbox"/> No
Competition athletics	<input type="checkbox"/> Yes <input type="checkbox"/> No
Physical education classes	<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