



REPORT OF PHYSICAL EXAMINATION

Student's Name		Gender <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	Pure Tone		<input type="checkbox"/> No abnormality
Muscle Balance	<input type="checkbox"/> Pass <input type="checkbox"/> Fail	Right ear	<input type="checkbox"/> Pass <input type="checkbox"/> Fail	<input type="checkbox"/> Screening not done
Stereopsis	<input type="checkbox"/> Pass <input type="checkbox"/> Fail	Left ear	<input type="checkbox"/> Pass <input type="checkbox"/> Fail	<input type="checkbox"/> Referral made
Color	<input type="checkbox"/> Pass <input type="checkbox"/> Fail	Child wears hearing aid?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comments: _____
Child wears glasses?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Child under the care		_____
Tested with glasses?	<input type="checkbox"/> Yes <input type="checkbox"/> No	of a hearing specialist?	<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	Lead Poisoning
Speech assessment completed <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Date _____ Type <input type="checkbox"/> C <input type="checkbox"/> V Results _____ μg/Dl
Child has no discernible speech problem <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Date _____ Type <input type="checkbox"/> C <input type="checkbox"/> V Results _____ μg/dL
Speech evaluation recommended <input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculin Test
Child has possible problem with _____	Date _____ Type _____ Results _____

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

<p>_____</p> <p>_____</p>

Physical 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	Physical education classes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Competition athletics	<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 progress?			

IMMUNIZATION RECORD

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.

Diphtheria, Tetanus, Pertussis (DTP)						
DTaP, Tdap						
DT, Td						
Polio						
Hepatitis B (HBV)						
Measles, Mumps, Rubella (MMR)						
Varicella (Chickenpox)						
Hepatitis A						
Meningoccal (MCV4, MPSV4)						
Pneumococcal (PCV)						
Measles (Rubeola) only						
Rubella only						
Mumps only						
Haemophilus influenza Type b (Hib)						
Influenza						
Other						

ADDITIONAL COMMENTS

HEALTH CARE PROVIDER INFORMATION

Health Care Provider's Signature	Print Name	Date
Address		Phone
City	State	ZIP

**Please return by fax (614-471-5035) or by mailing to:
 Columbus Adventist Academy
 3650B Sunbury Road
 Columbus, OH 43219**