REPORT OF PHYSICAL EXAMINATION

Student's Name		Gender ❑ Male ❑ Female	Date of Birth
Height	Weight	BMI Percentile	BP

SCREENING TESTS

Vision

Date Performed

Distance Acuity ❑ R ❑ L
Muscle Balance ❑ Pass ❑ Fail
Stereopsis ❑ Pass ❑ Fail
Color ❑ Pass ❑ Fail
Child wears glasses? ❑ Yes ❑ No
Tested with glasses? ❑ Yes ❑ No
Referral made? ❑ Yes ❑ No

Hearing

Date Performed

Pure Tone
Right ear ❑ Pass ❑ Fail
Left ear ❑ Pass ❑ Fail
Child wears hearing aid? ❑ Yes ❑ No
Child under the care of a hearing specialist? ❑ Yes ❑ No
Referral made? ❑ Yes ❑ No

Postural

Date Performed

❑ No abnormality
❑ 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

❑ 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 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.

Diptheria, 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						

HEALTH CARE PROVIDER INFORMATION

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

ADDITIONAL COMMENTS

Fax completed form to: ATTN: Records at 844-865-4124 or Mail to: 3650 B Sunbury Rd., Columbus, Ohio, 43219