OHIO SCHOOL HEALTH RECORD
PHYSICIAN'S REPORT

Child's Name _____ Male ____ Female ____ Age ____ Date _____

OBJECTIVE DATA

Height _____ (%) Weight _____ (%) B.P. _____/_____

SCREENING TESTS: Date Done _____

Vision
Distance Acuity R _____ L _____
Muscle Balance pass ☐ fail ☐ not done ☐
Farsightedness pass ☐ fail ☐ not done ☐
Color pass fail not done
Child wears glasses? yes ☐ no ☐
Tested with glasses? yes ☐ no ☐
Referral made? yes ☐ no ☐

Date Done_____

Hearing Audiometric thresholds:
R – ear pass ☐ fail☐ not done☐
L – ear pass ☐ fail☐ not done☐
Other tests (specify) _____
_____
Child wears hearing aid? yes ☐ no ☐
Tested with hearing aid? yes ☐ no ☐
Referral made: yes ☐ no ☐

SPEECH/LANGUAGE

Speech assessment: done☐ not done ☐
Child has no discernible speech problem: ☐
Child has possible problem with:
Disorders: (check) Articulation ☐ Rhythm ☐ Voice ☐ Language ☐
Speech evaluation recommended: yes ☐ no ☐

LABORATORY TESTS

Hct/Hgb _____ Lead level _____ Urine protein/blood _____ Urine glucose _____ Other _____

PHYSICAL EXAMINATION

Date examined _____ Essentially normal: yes ☐ no ☐
Abnormalities as follows:

_____

_____

_____

Allergies:_____

Is this child able to participate fully in the following?

A. Classroom and academic activities? yes ☐ no ☐
B. Physical education classes? yes no
C. Competitive athletics? yes no
D. Contact and collision sports? yes 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?

_____

_____

_____

PHYSICIAN'S ASSESSMENT

Problem List	Recommendation for school management
1.	1.
2.	2.
3.	3.

IMMUNIZATION RECORD

DPT _____ _____ _____ _____ _____

IPV _____ _____ _____ _____

Hep B _____ _____ _____ _____

Hib _____ _____ _____ _____

MMR _____ _____

Varicella _____ _____

Other _____ _____ _____

PLEASE PRINT OR STAMP

Physician's Name _____ Physician's Signature _____

Address _____

Phone _____ Date signed _____

OHIO SCHOOL HEALTH HISTORY

(Both sides to be completed by parent or guardian)

Child's Name_____
(Last) (First) (Middle)

☐ Male ☐ Female Date of Birth _____
(month) (day) (year)

Child's Address _____

Mother's Name _____

Address (if different from child's) _____

Home Phone _____ Work Phone _____

Father's Name _____

Address (if different from child's)_____

Home Phone _____ Work Phone _____

With whom does your child live? _____
(name) (relationship)

Who is this child's legal guardian? _____

Please list this child's brothers and sisters:

FAMILY HISTORY

Name	Birth Year	Sex	Name	Birth Year	Sex
1.			5.		
2			6.		
3.			7.		
4.			8.		

IMMUNIZATIONS

DPT #1_____ #2_____ #3_____ #4_____ #5_____
IPV #1_____ #2_____ #3_____ #4_____
Hep B #1_____ #2_____ #3_____ #4_____
Hib #1_____ #2_____ #3_____ #4_____
MMR #1_____ #2_____
Varicella#1_____ #2_____
Other _____ _____ _____

DEVELOPMENTAL HISTORY

Please give the approximate age at which this child:

walked alone _____ was toilet trained _____ spoke in sentences _____ dressed self _____

How does this child's development compare to other children, such as his or her brothers/sisters or playmates?

about the same_____ slower_____ faster_____

I. HEALTH CONDITIONS - Please check any that this child has had:

__ Abnormal spinal curvature (scoliosis, etc.)
__Allergies or hay fever
__Anemia
__Arthritis
__Asthma or wheezing
__Bedwetting at night
__Behavior problem
__Birth or congenital malformation
__Cancer – type _____
__Chicken pox
__Chronic diarrhea or constipation
__Concern about relationship with siblings or friends
__Cystic fibrosis
__Diabetes
__Eczema
__Emotional problems
__Eye problems, poor vision
__Frequent headaches
__Frequent skin infections
__Frequent sore throat infections
__Heart disease – type _____
__Hepatitis
__Kidney disease - type _____
__Measles ("old fashioned" or "ten day")
__Meningitis or encephalitis
__Multiple ear infections (3 or more)
__Mumps
__Near-drowning or near-suffocation
__Nervous twitches or tics
__Poisoning
__Poor hearing
__Pregnancy
__Rheumatic fever
__Seizures or epilepsy
__Sickle cell disease
__Stool soiling
__Substance abuse (alcohol, drugs)
__Suicide attempt
__Toothaches or dental infections
__Urinary tract infection
__Wetting during day

II. ALLERGIES – Please list and describe allergies or reactions to:

Medicines/drugs _____

Foods/plants/animals/other _____

Recommended treatment, if allergy is severe _____

III. INJURIES AND ILLNESSES – Please list any severe injuries or illnesses:

Injuries/Illnesses	Age of Child	If Hospitalized (check)
_____	_____	_____
_____	_____	_____
_____	_____	_____

Does this child always wear seat belts in cars? Yes No

IV. ADDITIONAL INFORMATION:

What medications are given daily? _____

What medications are given frequently, but not daily? _____

This child is usually: very active_____ normally active_____ rather inactive_____

Do you have any concern about how your child gets along with other children?
_____
_____

Do you have other comments or concerns about this child's health, development, behavior, family or home life that you would like the school to be aware of? If yes, explain briefly _____
_____
_____
_____
_____

Completed by: _____

Relationship to child: _____