Ohio Department of Health • School and Adolescent Health

Physical Examination

Student's name		Sex ☐ 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 noted
☐ 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 Date of most recent 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 process?

HealthCare Provider's signature	Print name	Phone ( )
Address		Date / /
City	State	ZIP

HEA 4242 8/06

Ohio
Department of Health

Ohio Department of Health
School and Adolescent Health
Immunization Report

Student's Name	Sex	Date of Birth
	☐ Male ☐ Female	/ /

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 should be on record.

Vaccine	Record complete dates (month, day, year) of vaccine doses given
Diphtheria, Tetanus, Pertussis (DTap,DT, Tdap, Td)	
Polio	
Hepatitis B (HBV)	
Measles, Mumps, Rubella (MMR)	
Varicella (Chicken pox)	
Hepatitis A	
Meningococcal (MCV4)	
Pneumococcal (PCV)	
Measles (Rubeola) only	
Rubella only	
Mumps only	
Haemophilus influenza Type b (Hib)	
Influenza	
Other	

This information was provided by ☐ Health Care Provider ☐ Parent/Guardian ☐ Other _____

Signature	Print Name	Date
		/ /

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