

Ohio Department of Health • School and Adolescent Health

Physical Examination (Physician)

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	Pure Tone		<input type="checkbox"/> No abnormality noted	
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 of a hearing specialist	<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	_____	
Referral made?	<input type="checkbox"/> Yes <input type="checkbox"/> No			_____	

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	