

**Ohio Department of Health • School and Adolescent Health**  
**Physical Examination**

Student's name			Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth / /
Height	Weight	BMI percentile	BP	

**Screening Tests**

<b>Vision</b>	<b>Hearing</b>	<b>Postural</b>
Date performed / /	Date performed / /	Date performed / /
Distance Acuity <input type="checkbox"/> R <input type="checkbox"/> L Muscle Balance <input type="checkbox"/> Pass <input type="checkbox"/> Fail Stereopsis <input type="checkbox"/> Pass <input type="checkbox"/> Fail Color <input type="checkbox"/> Pass <input type="checkbox"/> Fail Child wears glasses? <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	Pure Tone Right ear <input type="checkbox"/> Pass <input type="checkbox"/> Fail Left ear <input type="checkbox"/> Pass <input type="checkbox"/> Fail Child wears hearing aid? <input type="checkbox"/> Yes <input type="checkbox"/> No Child under the care of a hearing specialist <input type="checkbox"/> Yes <input type="checkbox"/> No Referral made? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> No abnormality noted <input type="checkbox"/> Screening not done <input type="checkbox"/> Referral made Comments _____ _____ _____

**Speech/Language**

**Lead Poisoning**

Speech assessment completed <input type="checkbox"/> Yes <input type="checkbox"/> No Child has no discernible speech problem <input type="checkbox"/> Yes <input type="checkbox"/> No Speech evaluation recommended <input type="checkbox"/> Yes <input type="checkbox"/> No Child has possible problem with _____	<input type="checkbox"/> Date _____ Type <input type="checkbox"/> C <input type="checkbox"/> V   Results _____ µg/dL <input type="checkbox"/> Date _____ Type <input type="checkbox"/> C <input type="checkbox"/> V   Results _____ µg/dL <b>Tuberculin Test</b> Date _____ Type _____ Results _____
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**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