OHIO SCHOOL HEALTH RECORD
PHYSICIANS'S REPORT

Child's Name:	Sex: ____ Male ____Female	Age:	Date:

I. Screening Tests

Vision Date:	Hearing Date:
Distance Acuity: Right _____ Left _____ 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	Pure tone testing: Right ear ___ pass ___ fail ___ not done Left ear ___ pass ___ fail ___ not done Other tests (specify): _____ Child wears hearing aid? ___ yes ___ no Tested with hearing aid? ___ yes ___ no Referral made? ___yes ___ no

II. Speech/Language

Speech assessment: ___ done ___ not done ___ child has no discernible speech problem
Child has problem with: ___ Articulation ___ Rhythm ___ Voice ___ Language
Speech evaluation recommended: ___ yes ___ no

III. Physical Examination

Date examined:

Height:	Weight:

___ Essentially normal Abnormalities as follows: _____
_____

Any required laboratory tests: _____

Is this child able to participate fully in the following:
A. Classroom and academic activities? ___ yes ___ no
B. Physical education classes? ___ yes ___ no
If limitations are advised, please specify: _____
_____
_____
_____

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. _____ 2. _____ 3. _____	1. _____ 2. _____ 3. _____
Physician's name:	**Physician's signature:**
Physician's Phone:	**Date signed:**
Physician's Complete address: **Street Address** **City** **State** **Zip**	

OHIO SCHOOL HEALTH RECORD
DENTIST'S REPORT

The following services have been performed:
___ Examination ___ Radiographs ___ Prescription for fluoride supplements
___ Diagnosis ___ Oral prophylaxis ___ Topical application of fluoride

The following oral hygiene instruction was provided:
___ Tooth brushing ___ Diet counseling reflecting relation of diet to dental health
___ Flossing ___ Home/school use of fluoride mouth rinse

The following statements are applicable:
___ All necessary services have been performed ___ Further treatment is indicated
___ No restorative services are required at this time ___ Further appointments have been arranged

Comments: _____
_____

Dentist's name: _____

Dentist's Phone:

Dentist's Complete Address:

Street Address **City** **State** **Zip**

Revised 2/06