Ohio School Health Record
Physician's Report

Child's Name_____ Male___ Female___ Date_____

OBJECTIVE DATA

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

SCREENING TEST

Date performed _____

Vision	Hearing
Distance Acuity R_____ L_____	Audiometric thresholds:
Muscle Balance ☐ pass ☐ fail ☐ n/a	R – ear ☐ pass ☐ fail ☐ n/a
Farsightedness ☐ pass ☐ fail ☐ n/a	L – ear ☐ pass ☐ fail ☐ n/a
Color ☐ pass ☐ fail ☐ n/a	Other tests (specify) _____
Child wears glasses ☐ yes ☐ no	_____
Tested with glasses ☐ yes ☐ no	Child wears hearing aid? ☐ yes ☐ no
Referral made? ☐ 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 ☐ Articulation ☐ Rhythm ☐ Voice ☐ Language
Speech evaluation recommended ☐ yes ☐ no

LABORATORY TESTS

☐ Hematocrit/Hemoglobin ☐ Urine protein ☐ Urine blood ☐ Urine glucose
☐ Other _____

PHYSICAL EXAMINATION

Date Examined_____
Essentially Normal ☐ yes ☐ no

Abnormalities as follows _____
_____
_____

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? _____
_____
_____
_____

-OVER-
PLEASE COMPLETE BOTH SIDES

PHYSICIAN'S ASSESSMENT

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

IMMUNIZATION RECORD

Vaccine	**Record complete dates of vaccine doses given** (month, day & year)					
Diphtheria, Tetanus, Pertussis						
Dtap, Tdap						
Polio						
Measles, Mumps, Rubella						
Haemophilus influenza Type b						
Hepatitis B (HBV)						
Hepatitis A						
Varicella						
Meningococcal (MCV4,MPSV4)						
Other						

Verification completed by _____ Date _____

PLEASE PRINT OR STAMP

Physician's name_____ Physician's signature_____

Address _____

Phone _____ Date signed _____

Please return to

ST. ANTHONY
SCHOOL

1300 Urban Drive · Columbus, Ohio 43229
p. 614-888-4268 · f. 614-888-4435

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PLEASE COMPLETE BOTH SIDES