

Ohio School Health History/Physical Assessment

Child's Name: _____ Age _____ Birth Date _____ Male Female

Ethnicity: Caucasian African American Hispanic Asian American Other

Objective Data: Height _____ Weight _____ B.P. _____

IMMUNIZATIONS					
Type	Date: Month/Day/Year				
Dtap, DPT, or DT					
DT/Td					
Polio					
MMR					
Hepatitis B					
Varicella					
HIB (prior to age 5 only)					
TB test					
Rotavirus <small>(given @ 2-4-6 mo, not after 12 months)</small>					
Other					

Screening Tests

Vision	Date:	Hearing	Date:
Distance Acuity: _____ Rt. _____ Lt. _____		Pure tone testing:	
Muscle Balance <input type="checkbox"/> pass <input type="checkbox"/> fail		Right ear <input type="checkbox"/> pass <input type="checkbox"/> fail	
Farsightedness <input type="checkbox"/> pass <input type="checkbox"/> fail		Left ear <input type="checkbox"/> pass <input type="checkbox"/> fail	
Color <input type="checkbox"/> pass <input type="checkbox"/> fail		Child wears hearing aid? <input type="checkbox"/> yes <input type="checkbox"/> no	
Stereopsis <input type="checkbox"/> pass <input type="checkbox"/> fail		Testing with hearing aid? <input type="checkbox"/> yes <input type="checkbox"/> no	
Child Wears glasses? <input type="checkbox"/> yes <input type="checkbox"/> no		Referral Made? <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			

Speech Assessment Date: _____

- Child has no dissemble speech problem
 Child has possible problem with: Articulation Rhythm Voice Language
 Speech evaluation is recommended Yes No

Physical Examination

Date of Examination: _____

- This child is essentially within normal limits
- This child is not within normal limits

Explain:

Does this child have any physical, developmental or behavioral problems?

Explain:

Activities & Limitations

Can the child participate fully in the following activities:

- Classroom and academic activities Yes No
- Physical education classes Yes No
- Competitive athletics Yes No
- Contact & collision sports Yes No

Specify any limitations:

Is this child on any medications? Yes No

Name of Medication	What is the medication taken for?	Time/Dosage
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

Allergies:

Please list and describe allergies or reactions:

Injuries, Illness & Hospitalizations

Please list any severe injuries, illnesses and hospitalizations:

Examiner's Signature: _____ **Date:** _____

Examiner's Printed Name: _____

Address: _____

Phone: _____