Ohio School Health Record
Physician's Report

Child's Name ____ Sex ☐ Male ☐ Female ____ Age ____ Date ____

Objective Data

Height ____ (%) Weight ____ (%) B.P. ____ /

Screening Tests

Vision ____ Date ____ Hearing ____ Date ____

Vision				Hearing			
Distance Acuity	Right _____	Left _____		Pure tone testing:			
Muscle Balance	☐ pass	☐ fail	☐ not done	Right ear	☐ pass	☐ fail	☐ not done
Farsightedness	☐ pass	☐ fail	☐ not done	Left ear	☐ pass	☐ fail	☐ not done
Color	☐ pass	☐ fail	☐ not done	Other tests (specify)			
Child wears glasses?	☐ yes	☐ no		Child wears hearing aid?	☐ yes	☐ no	
Tested with glasses?	☐ yes	☐ no		Tested with hearing aid?	☐ yes	☐ no	
Referral made?	☐ 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 Abnormalities as follows: ____

Is this child able to participate fully in the following?

Classroom / Academic activity	☐ yes	☐ no	Competition athletics	☐ yes	☐ no
Physical Education classes	☐ yes	☐ no	Contact / Collision sports	☐ 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?

Immunizations

DPT	/ /	/ /	/ /	/ /	/ /	/ /
TD	/ /	/ /	/ /	/ /	/ /	/ /
Polio	/ /	/ /	/ /	/ /	/ /	/ /
Measles (Rubeola)	/ /	/ /				
Rubella	/ /	/ /				
Mumps	/ /	/ /				
MMR Combined	/ /	/ /				
Heb B Series	/ /	/ /	/ /	/ /	/ /	/ /
Varicelia	/ /	/ /	/ /	/ /	/ /	/ /

Physician's Assessment

Problem ____ Recommendation for school management ____

Physician's Name ____ **Date** ____

Address ____

Phone ____ **Physician Signature** ____

Ohio School Health Record
Dentist's Report

The following services have been performed:

□ Examination
□ Diagnosis
□ Radiographs
□ Oral Prophylaxsis
□ Prescription for fluoride supplements
□ Topical application of fluoride

The following oral hygiene instruction was provided:

□ Toothbrushing
□ Flossing
□ Diet counseling reflecting relation of diet to dental health
□ Home / school use of fluoride mouthrinse

The following statements are applicable:

□ All necessary services have been performed
□ No restorative services are required at this time
□ Further treatment is indicated
□ Further appointments have been arranged

Comments: ____

____

____

____

Dentist's Name ______________________
Address ______________________
____
Phone ______________________

Date ______________________

Dentist's Signature ______________________

Ohio School Health History
[to be completed by parent or guardian]

Child's First – Middle – Last Name   □ Male   □ Female   Birth Date – Month – Day – Year

Child's Address (include P.O. Box if applicable)

Father's Name – Address – Home Phone – Cell Phone – Work Phone

Mother's Name – Address – Home Phone – Cell Phone – Work Phone

With whom does child live?   Who is this child's legal guardian?

Family History – Please list child's brothers and sisters

Name	Birth Year	Sex	Name	Birth Year	Sex

Perinatal History

Did the mother have any unusual physical or emotional illness during this pregnancy?
□ Yes   □ No   If yes, explain briefly ____________________

How old was the mother when this child was born?   Was this infant born? □ full term □ early □ late   What was this infant's birth weight?

Did the infant have any illness or problems while in the nursery?
□ Yes   □ No   If yes, explain briefly ____________________

Developmental History

Please give the approximate age at which this child:
□ Walked alone ________   □ Spoke in sentences ________   □ Was toilet trained ________   □ dressed self ________

How does this child's development compare to other children, such as his or her brothers/sisters or playmates?
□ About the same   □ Slower   □ Faster

Please check any that this child has had:

□ Abnormal spinal curvature (scoliosis, etc.)
□ Allergies or hayfever
□ Anemia
□ Asthma or wheezing
□ Bedwetting at night
□ Behavior problems
□ Birth or congenital malf.
□ Cancer, type ________
□ Chicken Pox
□ Chronic diarrhea or constipation
□ Concern about relation with siblings or friends
□ Cystic Fibrosis
□ Diabetes
□ Eczema
□ Emotional
□ Ear problems, poor hearing
□ Eye problems, poor vision
□ Frequent headaches
□ Frequent skin infections
□ Frequent sore throat infections
□ Heart disease, type ________
□ Hepatitis
□ Kidney disease, type ________
□ Measles (old fashioned or ten day)
□ Meningitis or encephalitis
□ Mumps
□ Near-drown'g / suffocation
□ Nervous twitches or tics
□ Poisoning
□ Pregnancy
□ Rheumatic Fever
□ Seizures or epilepsy
□ Sickle cell disease
□ Stool soiling
□ Substance abuse
□ Suicide attempt
□ Toothaches or dental infections
□ Urinary tract infection
□ Wetting during day

Allergies – List and describe allergies or reactions:

Medicine / Drugs ____________________
Foods / Plants / Animals / Other ____________________
Recommended treatment ____________________

Injuries and Illnesses – List any that were severe:

List any that were severe	Age of child	Check if hospitalized

Additional Information

Does child always wear seatbelts in cars?   □ Yes   □ No
Medications taken on a daily basis? ____________________
Medications given occasionally? ____________________
Do you have concern about how your child gets along with other children? ____________________
Is you child usually   □ very active   □ normally active   □ rather inactive
Other comments or concerns ____________________

Completed by: ____________________   Relationship to child: ____________________