Saint Raphael School
525 Dover Center Road
Bay Village, OH 44140
440-871-6760

OHIO SCHOOL HEALTH RECORD – PHYSICIANS REPORT

Child's Name	Gender	Age	Birthdate

Objective Data

Height	Weight	BP
(%)	(%)	/

IMMUNIZATIONS					
TYPE	DATE (MO/DAY/YEAR)				
DTAP, DPT or DT					
Hep A					
Hep B					
HIB					
MMR					
POLIO					
VARICELLA					
OTHER					
OTHER					

Screening Tests

Vision	Date:	Hearing	Date:
Distance Acuity	Right_____ Left_____	Pure tone testing:	
Muscle Balance	O Pass O Fail O Not Done	Right ear	O Pass O Fail O Not Done
Farsightedness	O Pass O Fail O Not Done	Left ear	O Pass O Fail O Not Done
Color	O Pass O Fail O Not Done	Other tests (specify)_____	
Child wears glasses?	O Yes O No	Child wears hearing aid?	O Yes O No
Tested with glasses?	O Yes O No	Tested with hearing aid?	O Yes O No
Referral made?	O Yes O No	Referral made?	O Yes O No

Speech/Languge

Speech Assesment	Date:			
Speech assessment:	O Done	O Not Done	O No discernible speech problems	
Child has possible problem with:	O Articulation	O Rhythm	O Voice	O Language
Speech evaluation recommended:	O Yes O No			

Laboratory Tests

O Hemacrit/Hemoglogin O Urine Protein O Urine Blood O Urine Glucose

O Other_____

Physical Examination/Assessment

Date of Examination:

O This child is essentially within normal limits

O This child is not within normal limits

Explain:_____

_____

_____

Does this child have any physical, developmental, or behavioral problems? Suggest special programs, placement or attention that the school can provide.

_____

_____

_____

PROBLEM LIST	RECOMMENDATION FOR SCHOOL MANAGEMENT
1._____	1._____
2._____	2._____
3._____	3._____
4._____	4._____

Activities & Limitations

Can the child participate fully in the following activities:

Classroom and academic activities	O Yes	O No
Physical education classes	O Yes	O No
Competitive athletics	O Yes	O No
Contact & collision sport	O Yes	O No

Specify any limitations:

_____

_____

_____

Medications

Does this child take any medications? O Yes O No

Explain:

_____

_____

_____

Examiner's Signature: _____ Date:_____

Examiner's Printed Name: _____

Address: _____

_____

Phone: _____