Ohio Department of Health * School and Adolescent Health

Physical Examination

Student's name		Sex ☐ Male ☐ Female	Date of birth / /
Height	Weight	BMI percentile	BP

Postural Screening Test

Date performed
/ /

☐ No abnormality noted
☐ Screening not done
☐ Referral made
Comments: ____________________________________

Allergies

☐ Food Allergies: ____
☐ Natural/Seasonal Allergies: __________________________________
☐ Animals: ____
☐ Medications: ____
☐ Other Allergies *(please specify)*: ___________________________

Speech/Language

Speech assessment completed	☐ Yes	☐ No
Child has no discernible speech problem	☐ Yes	☐ No
Speech evaluation recommended	☐ Yes	☐ No
Child has possible problem with ______________________		

Lead Poisoning

☐ Date_______________Type ☐ C ☐ V Results_____________μg/dL
☐ Date_______________Type ☐ C ☐ V Results_____________μg/dL

Tuberculin Test
Date_________________Type_______________Results
____

Health History (Serious or chronic illnesses/injuries/surgeries)

____

Physical Examination Date of most recent examination / /

☐ Essentially normal ☐ Abnormalities as follows:
____
____

Is this child able to participate fully in:

Classroom and academic activities	☐ Yes	☐ No	Physical education classes	☐ Yes	☐ No
Competition athletics	☐ Yes	☐ No	Contact and collision sports	☐ Yes	☐ No

If limitations are advised, please specify:
____
____

Does this child have any physical, developmental or behavioral issues that may affect his/her educational process?
____
____

HealthCare Provider's signature	Print name	Phone ( )
Address		Date / /
City	State	ZIP