Akron Children's Hospital
School Health Services

Physician Report
School Year:_____
Grade:_____

Name: _____ **Male** _____ **Female** _____

Date of Birth: _____

Height: _____(_____%ile) **Weight:** _____(_____%ile) **B.P.**_____ **Pulse:** _____

Vision	**Hearing**
Distance Acuity Right____ Left ____ Tested with glasses? ___ yes ___ no Muscle Balance: ___pass ___ fail ___not done Farsightedness: ___pass ___fail ___not done Color vision with pseudo Isochromic plates: ___pass ___fail ___not done Child wears glasses? ___yes ___no Glasses for: ___distance ___reading ___ all times Referral made? ___ yes ___ no	Pure Tone testing (20 dB @ 1000, 2000, 4000 Hz) Right Ear: ___ pass ___ fail Left Ear: ___ pass ___ fail Other tests (specify) _____ Child wears hearing aid? ___ 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

Physical Examination

Does this child require any special assistance during the school day? _____ yes _____ no
If yes, please explain:

_____

_____

Is child able to participate in the following?

Classroom and academic activities:	_____ yes	_____ no	Competitive athletics:	_____ yes	_____ no
Physical education classes:	_____ yes	_____ no	Contact sports:	_____ yes	_____ no

If limitations are advised, please explain these limitations:

_____

_____

Medications

Current Medications/Reason for Taking:

_____

_____

Will these medications need to be given at school? _____ yes _____ no

PLEASE COMPLETE FRONT AND BACK

Name: _____

Immunizations: (Required by Ohio Law, updated for 2012 school entry)

Vaccine	**1st Dose**	**2nd Dose**	**3rd Dose**	**4th Dose**	**5th dose**	**Comments**
DPT						**Kindergarten** 5th dose required if 4th dose before age 4 **Grades 1-12** 3-4 doses **Grades 7-9** **One (1) does of Tdap prior to entry**
Polio					**N/A**	Final dose required on or after 4th birthday
MMR			**N/A**	**N/A**	**N/A**	Two doses required for grades K-12
Hepatitis B				**N/A**	**N/A**	Three doses required for K-12
Varicella (Chicken Pox)		**K-2nd only**	**N/A**	**N/A**	**N/A**	**Kindergarten-2** One dose on or after the 1st birthday Second dose at least 28 days after 1st dose. **Grades 3-6** One dose on or after the 1st birthday
HIB						0-14 months: 3-4 doses or 15-59 months: 1 dose
TB Test	Negative	Positive				Not required for school entry
Other						

Lead Poisoning (PRESCHOOL ONLY):
Date_____Results_____

Hemoglobin/Hematocrit (PRESCHOOL ONLY):
Date_____Results_____

_____ _____
Physician Signature **Date** **Physician Name (please print)**

_____
Physician address

_____
Physician phone

7/09, 1/10, 4/12 **PLEASE COMPLETE FRONT AND BACK**