

WORTHINGTON SCHOOLS HEALTH RECORD  
WORTHINGTON OHIO  
PHYSICIAN'S REPORT

Child's Name \_\_\_\_\_ Male \_\_\_ Female \_\_\_ Age \_\_\_ Exam Date \_\_\_\_\_  
Birth date \_\_\_\_\_  
Month/Day/Year

OBJECTIVE DATA:

Height \_\_\_\_\_ ( %) Weight \_\_\_\_\_ ( %) B.P. \_\_\_\_\_

SCREENING TESTS: Date done \_\_\_\_\_

Vision  
Distance Acuity R \_\_\_ L \_\_\_  
Muscle Balance pass \_\_\_ fail \_\_\_ not done \_\_\_  
Farsightedness pass \_\_\_ fail \_\_\_ not done \_\_\_  
Color pass \_\_\_ fail \_\_\_ not done \_\_\_  
Child wears glasses? yes \_\_\_ no \_\_\_  
Tested with glasses? yes \_\_\_ no \_\_\_  
Referral made? yes \_\_\_ no \_\_\_

Hearing Date done \_\_\_\_\_

Audiometric thresholds:  
R-ear pass \_\_\_ fail \_\_\_ not done \_\_\_  
L-ear pass \_\_\_ fail \_\_\_ not done \_\_\_  
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:

Disorders: (check) 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?

- A. Classroom and academic activities? yes \_\_\_ no \_\_\_
- B. Physical education classes? yes \_\_\_ no \_\_\_
- C. Competitive athletics? yes \_\_\_ no \_\_\_
- D. Contact and collision sports? yes \_\_\_ no \_\_\_

If limitations are advised, please specify those limitations:

If this child has any physical, developmental or behavioral problems, how can the school assist with special programs, placement or attention?

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Immunizations given at time of exam \_\_\_\_\_

PHYSICIAN'S ASSESSMENT

Problem list	Recommendation for school management
1.	1.
2.	2.
3.	3.

PLEASE PRINT OR STAMP

Physician's name \_\_\_\_\_

Physician's signature \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

Date signed \_\_\_\_\_