

**Norwood City Schools**  
**Ohio School History**  
 Physician Assessment

School: \_\_\_\_\_  
 Enrolled: \_\_\_\_\_

Name: \_\_\_\_\_ Gender: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_

Ethnicity:  Caucasian  African American  Hispanic  Asian American  Other

Objective Data:

Height \_\_\_\_\_ Weight: \_\_\_\_\_ B.P.: \_\_\_\_\_

**IMMUNIZATION**

Required for school entry

TYPE	DATE: MO/DAY/YEAR				
DtaP, DPT or DT					5 <sup>th</sup> dose required if 4 <sup>th</sup> dose given before 4 <sup>th</sup> b-day for <b>Kindergarten</b>
DT/Td					<b>Grades 1-12*</b> : 3-4 doses of DtaP, DTP, DT or Td or any combination <b>Grade 7-9: 1 dose of Tdap or Td prior to entry into 7<sup>th</sup> grade</b>
POLIO					<b>K-1</b> students must have 3 or 4 doses of IPV, final dose on or after 4 <sup>th</sup> bday; 4 doses if a combination of OPV/IPV. <b>Grades 2-12</b> 4 doses if combination IPV/OPV. 4 doses if all IPV/OPV & if the final dose was given before 4 <sup>th</sup> birthday
MMR					<b>KG-12</b> : 2 doses required for 2011-12
HEPATITIS B					<b>K-12</b> : 3 doses required for 2011-12
VARICELLA					<b>K-2</b> must have 2 doses for 2011-12 <b>Gr. 3-5</b> must have 1 dose for 2011-12
HIB (prior to age 5 only)					0-14 months; 3-4 doses, 5-59 months; 1 dose
TUBERCULIN TEST					<b>Required if traveled to high-risk area</b>
ROTAVIRUS (given @ 2-4-6 mo. Not after 12 mos.)					
OTHER					

**SCREENING TESTS**

Vision:	Date:	Hearing:	Date:
Distance Acuity Right _____ Left _____ Muscle Balance <input type="checkbox"/> Pass <input type="checkbox"/> Fail <input type="checkbox"/> Not Done Farsightedness <input type="checkbox"/> Pass <input type="checkbox"/> Fail <input type="checkbox"/> Not Done Color <input type="checkbox"/> Pass <input type="checkbox"/> Fail <input type="checkbox"/> Not Done Child Wears Glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No Tested With Glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No Referral Made? <input type="checkbox"/> Yes <input type="checkbox"/> No Specify Test/Equipment: _____		Pure Tone Testing: Right Ear <input type="checkbox"/> Pass <input type="checkbox"/> Fail <input type="checkbox"/> Not Done Left Ear <input type="checkbox"/> Pass <input type="checkbox"/> Fail <input type="checkbox"/> Not Done Child Wears Hearing Aid? <input type="checkbox"/> Yes <input type="checkbox"/> No Testing With Hearing Aid? <input type="checkbox"/> Yes <input type="checkbox"/> No Referral Made? <input type="checkbox"/> Yes <input type="checkbox"/> No Other Test(specify): _____	

**SPEECH ASSESSMENT**

Date: \_\_\_\_\_

Child has no discernable speech problem  
 Child has possible problem with:  Articulation  Rhythm  Voice  Language  
 Speech evaluation is recommended:  Yes  No

## LABORATORY TESTS

**\*\*ODH Lead Testing Requirement: ages 6-72 months**

- |   |
|---|
| <input type="checkbox"/> Hemoglobin/Hematocrit <input type="checkbox"/> Urine Protein <input type="checkbox"/> Urine Blood <input type="checkbox"/> Urine Glucose<br><input type="checkbox"/> **BLL (Blood Lead Level): _____ |
|---|

## PHYSICAL EXAMINATION

**\*\*Preschool students must have a signed physician exam on file with the school within 30 days of admission, renewed every year while in Preschool. The exam must have been given within the year.**

Date of Examination: \_\_\_\_\_

- This child is essentially within normal limits
- 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.

## ACTIVITIES & LIMITATIONS

Can the child participate fully in the following activities?

- |                                   |  |
|-----------------------------------|--|
| Classroom and academic activities | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Physical Education classes        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Competitive Athletics             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Contact & Collision Sports        | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Specify any limitations:

Is this child on any medications?       Yes  No

Explain:

Examiner's Signature: \_\_\_\_\_ Date signed: \_\_\_\_\_

Examiner's Printed Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

ORAL ASSESSMENT

Child's Name: _____ Gender: <input type="checkbox"/> M or <input type="checkbox"/> F Age: _____ DOB: _____
Ethnicity: <input type="checkbox"/> Caucasian <input type="checkbox"/> African American <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian American <input type="checkbox"/> Other

The following services have been performed:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Examination by Dentist      | <input type="checkbox"/> Orthodontic Assessment | <input type="checkbox"/> Oral Screening              |
| <input type="checkbox"/> Dental Sealants             | <input type="checkbox"/> Radiographs            | <input type="checkbox"/> Fluoride Application        |
| <input type="checkbox"/> Oral Prophylaxis (cleaning) | <input type="checkbox"/> Diagnosis              | <input type="checkbox"/> Rx for fluoride supplements |

The following oral hygiene instruction was provided:

- |   |   |
|---|---|
| <input type="checkbox"/> Brushing teeth | <input type="checkbox"/> Diet counseling related to dental health |
| <input type="checkbox"/> Flossing       | <input type="checkbox"/> Home/school use of fluoride mouth rinse  |

The following statements are applicable:

- No apparent care needed at this time.
- All necessary preventative services have been performed. (Fluoride treatment, prophylaxis)
- No restorative services are required at this time.
- Further treatment is indicated. (See comments)
- Further appointments have been arranged. (ex. Orthodontic, restorative)

Comments:

Examiner's Signature: \_\_\_\_\_ Date signed: \_\_\_\_\_

Examiner's Printed Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_