



Pre-School (circle one)

Ohio School History Physician Assessment

Sharpsburg - Williams

Enrolled: _____

Name: _____ Gender: _____ Age: _____ DOB: _____

Ethnicity: Caucasian African American Hispanic Asian American Other

Objective Data:

Height _____ Weight: _____ B.P.: _____

Table with columns: TYPE, DATE: MO/DAY/YEAR. Rows include DtaP, DPT or DT; DT/Td; POLIO; MMR; HEPATITIS B; VARICELLA; HIB; TUBERCULIN TEST; ROTAVIRUS; MCV4. Includes specific requirements for each vaccine.

SCREENING TESTS

Form for Vision and Hearing screening tests. Includes fields for Distance Acuity (Right/Left), Muscle Balance, Farsightedness, Color, Child Wears Glasses?, Tested With Glasses?, Referral Made?, and Pure Tone Testing (Right/Left Ear, Child Wears Hearing Aid?, Testing With Hearing Aid?, Referral Made?).

SPEECH ASSESSMENT form. Includes Date: _____ and checkboxes for: Child has no discernable speech problem; Child has possible problem with: Articulation, Rhythm, Voice, Language; Speech evaluation is recommended: Yes/No.

Physician Assessment (CONTINUED)

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
<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 Yes No
- Physical Education classes Yes No
- Competitive Athletics Yes No
- Contact & Collision Sports Yes No

Specify any limitations:

Is this child on any medications? Yes No

Explain:

Examiner's Signature: _____ Date signed: _____

Examiner's Printed Name: _____

Address: _____

Phone: _____