

## Physician's Report

**\*School Nurse must have on file within 30 days of starting school\***

School Student Attends: \_\_\_\_\_

**When completed, this form may be faxed directly to the building of attendance: Richfield: 330-659-6701  
 Bath Elem: 330-666-3058  
 Revere Middle School: 330-659-3795  
 Revere High School: 330-659-6407**

Child's name	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Age	Date
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**Objective data**

Height ( %)	Weight ( %)	B.P.	Pulse
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**Screening Tests**

VISION	Date	HEARING	Date
Distance Acuity right _____ left _____		Pure tone testing (20 dB @ 1000, 2000, 4000 Hz)	
Tested with glasses? <input type="checkbox"/> yes <input type="checkbox"/> no		Right ear <input type="checkbox"/> pass <input type="checkbox"/> fail <input type="checkbox"/> not done	
Muscle Balance <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	
Farsightedness <input type="checkbox"/> pass <input type="checkbox"/> fail <input type="checkbox"/> not done		Other tests (specify) _____	
Random Dot E <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	
Color vision with pseudo-isochromic plates <input type="checkbox"/> pass <input type="checkbox"/> fail <input type="checkbox"/> not done		Tested with Hearing aid? <input type="checkbox"/> yes <input type="checkbox"/> no	
Child wears glasses? <input type="checkbox"/> yes <input type="checkbox"/> no		Referral made? <input type="checkbox"/> yes <input type="checkbox"/> no	
Glasses worn for: <input type="checkbox"/> distance <input type="checkbox"/> reading <input type="checkbox"/> at all times			
Referral made? <input type="checkbox"/> yes <input type="checkbox"/> no			

**Speech/Language**

Speech assessment: <input type="checkbox"/> done <input type="checkbox"/> not done <input type="checkbox"/> Child has no discernible speech problem
Child has possible problem with: <input type="checkbox"/> Articulation <input type="checkbox"/> Rhythm <input type="checkbox"/> Voice <input type="checkbox"/> Language
Speech Evaluation recommended: <input type="checkbox"/> Yes <input type="checkbox"/> No

**Laboratory Tests**

<input type="checkbox"/> Hematocrit /Hemoglobin	<input type="checkbox"/> Urine protein	<input type="checkbox"/> Urine blood	<input type="checkbox"/> Urine glucose	<input type="checkbox"/> Other: _____
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**Physical Examination:**

Date examined	
<input type="checkbox"/> Essentially normal	Abnormalities as follows: _____ _____ _____

Is this child able to participate fully in the following:

A. Classroom and academic activities? <input type="checkbox"/> yes <input type="checkbox"/> no	C. Competitive athletics? <input type="checkbox"/> yes <input type="checkbox"/> no
B. Physical education classes? <input type="checkbox"/> yes <input type="checkbox"/> no	D. Contact and collision sports? <input type="checkbox"/> yes <input type="checkbox"/> no

If limitations are advised, please specify those limitations:

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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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**Medications:**

If this child is taking any medication, please list medication and reason for taking:

Medication	Reason for taking

**Immunizations:** Ohio Law describes minimum requirements for school entrance.  
Separate print-out from doctor's office with the needed information is acceptable.  
Please staple to back of this form.

Type:	Record	Month/Day/Year
DTaP, DPT, DT	_____	_____
Td, TDaP	_____	_____
Polio, OPV, IPV	_____	_____
MMR	_____	_____
Hepatitis B	_____	_____
Varivax (chickenpox)	_____	_____ (date of vaccine or disease)
HIB	_____	_____
Pevnar (pneumococcal)	_____	_____ Recommended.
TB Test	_____	Result: Neg. _____ or Pos. _____ Optional
Other	_____	_____

**Please print or stamp (Required):**

Doctor's name	Doctor's signature
Address	Date signed
Phone	