Revere Local Schools 3496 Everett Rd, Richfield, OH 44286

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 □ Male □ Female	Age	Date of Birth

Objective data

Height (%)	Weight (%)	B.P. /	Pulse

Screening Tests

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

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 C. Competitive athletics? □ yes □ no

B. Physical education classes? □ 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?

_____
_____
_____

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	_____	_____	_____	_____	
Prevnar (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	