School: Hillcrest Elementary

Physician's Report

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

Form may be Faxed directly to 330-659-6701 (Hillcrest Elementary School / Attn: Nurse)

Child's name	Sex □ Male □ Female	Age	Date

Objective data

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

Screening Tests

VISION	Date		
Distance Acuity	right _____	left _____	
Tested with glasses?	□ yes	□ no	
Muscle Balance	□ pass	□ fail	□ not done
Farsightedness	□ pass	□ fail	□ not done
Random Dot E	□ pass	□ fail	□ not done
Color vision with pseudo-isochromic plates	□ pass	□ fail	□ not done
Child wears glasses?	□ yes	□ no	
Glasses worn for:	□ distance	□ reading	□ at all times
Referral made?	□ yes	□ no	

HEARING	Date		
Pure tone testing	(20 dB @ 1000, 2000, 4000 Hz)		
Right ear	□ pass	□ fail	□ not done
Left 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:	□ 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?

_____

_____

_____

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	