

**Bay Village School District
Health Record and Physician's Report**

Grade: _____ Date of Birth _____

Child's Name _____ Male _____ Female _____ Age _____ Date _____

OBJECTIVE DATA: Height _____ (_____ %) Weight _____ (_____ %) Blood Pressure _____

SCREENING TESTS: Vision Date done _____ **Hearing** Date done _____

Distance Acuity Right _____ Left _____
Muscle Balance pass _____ fail _____ not done _____
Farsightedness pass _____ fail _____ not done _____
Color pass _____ fail _____ not done _____

Audiometric thresholds:
R ear pass _____ fail _____ not done _____
L ear pass _____ fail _____ not done _____
Other tests (specify) _____

Child wears glasses? yes _____ no _____
Tested with glasses? yes _____ no _____
Referral made? yes _____ no _____

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 _____

Disorders: (check) Articulation _____ Rhythm _____ Voice _____ Language _____

Speech evaluation recommended: yes _____ no _____

Recommended New Screening as of (2008)

Hematocrit _____

Physician does not agree to test

Reason given _____

Recommended New Screening as of (2008)

Lead _____

Physician does not agree to test

High risk area does not exist

Reason given _____

Optional Tests:

Urine Protein _____ Urine blood _____ Urine glucose _____

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:

Grade _____

Child's full name _____
Last First Middle

If this child has any physical, developmental or behavioral problems, how can the school assist with special programs, placement or attention?

PHYSICIAN'S ASSESSMENT

Problem List

Recommendation for school management

1.	1.
2.	2.
3.	3.

PLEASE PRINT OR STAMP

Physician's name _____ Signature _____

Address _____

Phone _____ Date _____

IMMUNIZATION RECORD COMPLETE DATES (MONTH, DAY, YEAR)

TYPE						
DTP						
POLIO						
HIB						
HEPATITIS B						
VARICELLA						
MMR						
PCV						
OTHER						