SANDUSKY CITY SCHOOLS HEALTH RECORD - PHYSICIAN'S REPORT

(For Kindergarteners and new students (grades 1 through 4) who receive their physical from their family physician.)

Child's Name ______________________ Birth Date ____________ Age __ Sex: M___ F___

OBJECTIVE DATA:

Height ______________ Weight ______________ B.P. ______/______ P __________

SCREENING TESTS: Date tested __________

Vision

Distance Acuity R ____ L ____
Muscle Balance pass ____ fail ____ not tested ____
Farsightedness pass ____ fail ____ not tested ____
Color pass ____ fail ____ not tested ____
Child wears glasses? yes ____ no ____
Tested with glasses? yes ____ no ____
Referral made? yes ____ no ____

Hearing Date tested __________

Audiometric thresholds:
R - ear pass ____ fail ____ not tested ____
L - ear pass ____ fail ____ not tested ____
Other tests (specify) ______________________

Child wears hearing aid? yes ___ no ___
Tested with hearing aid? yes ___ no ___
Referral made? yes ___ no ___

SPEECH/LANGUAGE

Speech assessment: tested ______ not tested ______ Child has no discernible speech problem ______

Child has possible problem with: (check) 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 ___

If limitations are advised, please specify those limitations: ______________________

____

____

____

Please list any physical, developmental, or behavioral problems

PHYSICIAN'S ASSESSMENT

Problem list	Recommendation for school management
1.	1.
2.	2.
3.	3.

Please complete information on reverse side.

Form 30-2 1215 06/11/01 revised

IMMUNIZATION

TYPE	DATE MO/DAY/YR					
DPT						
DTaP						
TD						
POLIO						
MMR						
Hib-d						
Hep B						
TUBERCULIN						
OTHER						

PLEASE PRINT OR STAMP

Physician's name ____________________ Physician's signature ____________________

Address ____________________

Phone ____________________ Date signed ____________________

SANDUSKY CITY SCHOOLS HEALTH RECORD - DENTIST'S REPORT

The following services have been performed:

____ Examination
____ Radiographs
____ Prescription for fluoride supplements
____ Diagnosis
____ Oral prophylaxis
____ Topical application of fluoride

The following oral hygiene instruction was provided:

____ Diet counseling reflecting relation of diet to dental health
____ Home/school use of fluoride mouthrinse
____ Flossing
____ Toothbrushing

The following statements are applicable:

____ All necessary services have been performed
____ No restorative services are required at this time
____ Further appointments have been arranged

Comments: ____________________

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PLEASE PRINT OR STAMP

Dentist's name ____________________ Dentist's signature ____________________

Address ____________________

Phone ____________________ Date signed ____________________