TO BE COMPLETED BY PHYSICIAN – MUST BE ON FILE BY THE FIRST DAY OF SCHOOL

Rossford Exempted Village Schools Health Report

Physician's Report

Fax to (419) 932-6350

Email: Enroll@rossfordschools.org

Child's Name; ______________________ Male _____ Female _____ School; ______________________

Birth Date: ______________ Age; ________ Height; ________ (%) Weight: ________ (%) Blood Pressure; __________

TYPE	IMMUNIZATION DATA- DATE; MONTH/DAY/YEAR				
DPTORDT	1. / /	2. / /	3. / /	4. / /	6. / /
Polio	1. / /	2. / /	3. / /	4. / /	
MMR	1. / /	2. / /			
HepB	1. / /	2. / /	3. / /		
Varicella	1. / /	2. / /			
HIB	1. / /	2. / /	3. / /	4. / /	
Other	1 . 1 1	2. 1 1	3. / /	4. / /	

Pdwo requiredII 4* doso given bolero ago 4

2nd dose required for kindergarten

0-14 months: 3-4 doses 15-59 months

Exempl Irom immunizations: Religious eonvlclton _____ Health concern _____ Other (explain) ______________________

Physical Examination:

_____ *77i/s child is essentially within normal limits.*

_____ *This child is not within limits. Explain;*

Date Examined: ______________________

Laboratory Tests

a Hematocvit Results: ______________________ □ Lead Results: ______________________

Screening Tests:

*Vision ______________ Date; ______________

Distance Acuity Right ______ Left ______

Muscle Balance ____Pass ____Fail ____Not Done

Farsightedness ____Pass ____Fail ____Not Done

Color ____Pass ____Fail ____Not Done

Child wears glasses? ____Yes ____No

Tested with glasses? ____Yes ____No

Referral made? ____Yes ____No

Specify Test/Equlpment __)______________________

Lead screening completed ______________________

*Hearing ______________ Date: ______________

Pure tone testing:

Right Ear ____Pass ____Fail ____Not Done

Left Ear ____Pass ____Fail ____Not Done

Child wears hearing aid? ____Yes ____No

Testing with hearing aid? ____Yes ____No

Referral made? ____Yes ____No

Other testing (specify) ______________________

____

Hemoglobin screening completed ______________________

*Speech

□ Child has no discernible speech problem

□ Child has possible problem with: _____Articulation _____Rhythm _____Voice _____Language

Speech evaluation Is recommended ____Yes ____No

* *Does f/i/s child have any physical, developmental or behavioral problems?* ____*Yes* ____*No*

* *Suggest special programs, plaoemenls or attention that the school can provide.*

Dontal: Oral Assessment: Findings: ______________________ Has child visited a dentist? ____Yes ____No

Activities & Limitations:

* *Can the child participate lully in the following activities:*

Classroom and academic activities ____Yes ____No

Contact & collision sports ____Yes ____No

Competitive athletics ____Yes ____No

Physical education classes ____Yes ____No

**Specify any limitations:* ______________________

Examiner's Signature; ______________________ Date: ______________ Phone: ______________

Print Name: ______________________ Address: ______________________