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

Vision: Date tested_____
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 If limitations are advised, please specify those limitations:_____
_____

B. Physical education classes? ___yes ___no If limitations are advised, please specify those limitations:
_____
_____

PHYSICIAN'S ASSESSMENT: Please list any physical, developmental, or behavioral problems.

Problem list
1. _____
2. _____
3. _____

Recommendation for school management
1. _____
2. _____
3. _____

Please complete information on reverse side.

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** _____

DENTIST'S REPORT

The following services have been performed:

___Examination
___Diagnosis
___Radiographs
___Oral prophylaxis
___Prescription for fluoride supplements
___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 mouth rinse

The following statements are applicable:

___All necessary services have been performed
___Flossing
___Tooth brushing
___No restorative services are required at this time
___Further appointments have been arranged

Comments:_____

_____

PLEASE PRINT OR STAMP

Dentist's name _____ **Dentist's signature** _____

Address_____

Phone_____ **Date signed** _____