Avon Lake City Schools

Ohio School Health Record

Physician's Report

Please PRINT

Date of Examination ___/___/___

Please note that these are the only medical forms that will be accepted by Avon Lake City Schools for Kindergarten registration – we will not accept medical forms from your doctor's office.

Student's Last Name _____ First _____ Middle _____

Male _____ Female _____ Age _____ Date _____

OBJECTIVE DATA

Height _____ (_____%) Weight _____ (_____%) B.P._____

SCREENING TESTS

Vision Screening Date of Screening _____

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 _____	

Hearing Screening Date of Screening _____

Audiometric thresholds:

Right ear	Pass _____	Fail _____	Not Done _____
Left ear	Pass _____	Fail _____	Not Done _____

Other tests (please 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:	Yes _____	No _____
Child has possible problem with:		
Disorders: (please check)	Articulation_____	Rhythm _____ Voice _____ Language ____
Speech evaluation recommended:	Yes _____	No _____

LABORATORY TESTS

Hematocrit/Hemoglobin_____ Urine Blood _____ Other _____

Urine Protein _____ Urine Glucose _____

Student's Name_____

PHYSICAL EXAMINATION

Date Examined _____ Essentially Normal _____

Abnormalities as follows:_____
_____
_____

Is this child able to participate fully in the following?

Classroom and academic activities:	Yes _____	No_____
Physical education classes:	Yes _____	No_____
Competitive athletics:	Yes _____	No_____
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? _____
_____
_____

Has this child had any immunizations today? Yes _____ No_____

If so, which ones? _____

PHYSICIAN'S ASSESSMENT

Problem List:	Recommendation for actual management:
1._____	1._____
2._____	2._____
3._____	3._____

PLEASE PRINT OR STAMP

Physician's Name _____

Physician's Signature _____

Address _____

Phone (_____)_____ Date Signed _____

"The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information with responding to this request for medical information. "Genetic Information" as defined by GINA, includes an individual's family medical history, the result of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services."