Akron Children's Hospital
SCHOOL HEALTH SERVICES

Physician/Healthcare Provider Report

School Year:_____ **Grade:**_____

Name: _____ **Male** _____ **Female** _____ **Date of Birth:** _____

Height: _____(_____%ile) **Weight:** _____(_____%ile) **B.P.:**_____ **Pulse:** _____

Vision	Hearing
Distance Acuity Right____ Left ____ Tested with glasses? ___ yes ___ no Muscle Balance: ___ pass ___ fail ___ not done Farsightedness: ___ pass ___ fail ___ not done Color vision with pseudo Isochromic plates: ___ pass ___ fail ___ not done Child wears glasses? ___ yes ___ no Glasses for: ___ distance ___ reading ___ all times Referral made? ___ yes ___ no	Pure Tone testing (20 dB @ 1000, 2000, 4000 Hz) Right Ear: ___ pass ___ fail Left Ear: ___ pass ___ fail Other tests (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
Child has possible problem with: ____ Articulation ____ Rhythm ____Voice ____Language
Speech Evaluation recommended: ____ yes ____no

Physical Examination

Does this child require any special assistance during the school day? _____ yes_____ no
If yes, please explain:

_____

_____

Is child able to participate in the following?

Classroom and academic activities:	_____ yes	_____ no	Competitive athletics:	_____ yes	_____ no
Physical education classes:	_____ yes	_____ no	Contact sports:	_____ yes	_____ no

If limitations are advised, please explain these limitations:

_____

_____

Medications

Current Medications/Reason for Taking:

_____

_____

Will these medications need to be given at school? _____ yes _____ no

PLEASE COMPLETE FRONT AND BACK

Name: _____

Immunizations: (Required by Ohio Law)

Vaccine	1st Dose	2nd Dose	3rd Dose	4th Dose	5th dose	Comments
DPT						**Preschool** 1 dose to start **Kindergarten** 5th dose required if 4th dose before age 4 **Grades 1-12** 3-4 doses Grades 7-12 One (1) dose of Tdap prior to entry
Polio					N/A	**Preschool 1 dose to start** Final dose required on or after 4th birthday
MMR			N/A	N/A	N/A	**Preschool 1 dose to start** Two doses required for grades K-12
Hepatitis B				N/A	N/A	**Preschool 1 dose to start** Three doses required for K-12
Varicella (Chicken Pox)			**N/A**	**N/A**	**N/A**	**Preschool 1 dose to start** **Kindergarten-5** One dose on or after the 1st birthday Second dose at least 28 days after 1st dose. **Grades 6-9** One dose on or after the 1st birthday
HIB (preschool entry)					N/A	0-14 months: 3-4 doses OR 15-59 months: 1 dose
Hepatitis A (preschool entry)			N/A	N/A	N/A	First dose between 12-23 months Second dose 6-18 months later
Pneumoncoccal Disease (preschool entry)					N/A	4 doses at 2, 4, 6 months and between 12-18 months
Influenza (preschool entry)			N/A	N/A	N/A	2 doses at least 4 weeks apart for age 6 mo to 8 years if first time dose. After first dose annually.
Rotavirus (preschool entry)				N/A	N/A	3 doses at 2, 4 and 6 months

Lead Poisoning (PRESCHOOL ONLY):

Date_____ Results_____

Hemoglobin/Hematocrit (PRESCHOOL ONLY):

Date_____ Results_____

_____ _____ _____

Physician/Healthcare Provider Signature **Date** **Physician/Healthcare Provider Name (please print)**

_____ _____

Physician/Healthcare Provider address **Physician/Healthcare Provider phone**

7/09, 1/10, 4/12, 6/14, 6/15

PLEASE COMPLETE FRONT AND BACK