

Healthcare Provider Report

Child's Name	Birthdate: Sex: Male [] Female []	
OBJECTIVE DATA		
*Height: (%) *Weight: (%) *BMI: (%) B P:/		
* Reason Not completed(ex. Healthcare provider decision, insurance coverage, religious conviction) Allergies:		
SCREENING TESTS		
VISION Date * If <u>not completed</u> , please explain t	below HEARING Date * If not completed, please explain below	
Screening equipment utilized:	Pure tone testing: 1200, 2000, 4000 (HZ) at 20 Decibles	
Distance Acuity OD:_20/ OS:_20/	Right ear □ pass □ fail □ not done	
1 1	ot done Left ear	
,	ot done	
Child wears glasses? ☐ yes ☐ no Tested with glasses? ☐ yes ☐ no	Other tests (specify) History of Otitis Media □ yes □ no // Insertion of PE tubes □ yes □ no Date:	
Referral made?	Referral made?	
_,	Child wears hearing aid? ☐ yes ☐ no	
* Reason Not completed(ex. Healthcare provider decision, insurance coverage, rel	* Reason Not completed(ex. Healthcare provider decision, insurance coverage, religious conviction)	
conviction)		
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:		
LABORATORY TESTS/Other tests		
□*Hemoglobin □ *Lead level	Atlantoaxial Instability x-ray (required Down Syndrome): Date: □ Done □ Not done	
*Reason Not completed(ex. Healthcare provider decision, insurance coverage, religious conviction)		
PHYSICAL EXAMINATION: *Please include an <i>updated copy</i> of the immunization records with this form		
Date of examination:		
le this shild able to participate fully in the following:		
Is this child able to participate fully in the following: A. Classroom and academic activities? □ YES □ NO		
B. Gross motor activities such as running, tumbling, climbing, etc.? \Begin{array}{ c c c c c c c c c c c c c c c c c c c		
If limitations are advised, please specify those limitations:		
Other limitations or health concerns?		
IMMUNIZATIONS **Please inclu	ude an updated copy of the immunization record with this form	
IMMUNIZATIONS::	EXEMPT FROM IMMUNIZATION:	
Complete for age □ YES □ NO □ N	Religious exemption: ☐ YES ☐ NO Health Exemption: ☐ YES ☐ NO	
Explain:	Other	
	#December 2242 674 of Ohio Douised Code on immunication waiten according to the control of the c	
*Per section 3313.671 of Ohio Revised Code an immunization waiver must be completed for all exemptions.		
PLEASE PRINT OR STAMP		
Healthcare provider name:	Healthcare provider signature:	
<u> </u>		
Address		
Phone	Data signed	
Phone	Date signed	