Our Lady of the Visitation School

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 not completed, please explain below

Screening equipment utilized:_____

Distance Acuity OD:_20/_____ OS:_20/_____

Random Dot E/Stereopsis ☐ pass ☐ fail ☐ not done

Near Acuity ☐ pass ☐ fail ☐ not done

Child wears glasses? ☐ yes ☐ no

Tested with glasses? ☐ yes ☐ no

Referral made? ☐ yes ☐ no

* Reason Not completed(ex. Healthcare provider decision, insurance coverage, religious conviction) _____

HEARING Date * If not completed, please explain below

Pure tone testing: 1200, 2000, 4000 (HZ) at 20 Decibles

Right ear ☐ pass ☐ fail ☐ not done

Left ear ☐ pass ☐ fail ☐ not done

Typanometry/Impedance ☐ pass ☐ fail ☐ not done

Other tests (specify)_____

History of Otitis Media ☐ yes ☐ no // Insertion of PE tubes ☐ yes ☐ no Date: _____

Referral made? ☐ yes ☐ no

Child wears hearing aid? ☐ yes ☐ no

* Reason Not completed(ex. Healthcare provider decision, insurance coverage, religious conviction) _____

LABORATORY TESTS/ OTHER TESTS

☐ **Hemoglobin*_____ ☐ **Lead level* _____ ☐ Tuberculin Test: Date: _____ Type:_____ Result: _____

*Reason Not completed(ex. Healthcare provider decision, insurance coverage, religious 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: ☐ Yes ☐ No

PHYSICAL EXAMINATION: ***Please include an *updated copy* of the immunization record with this form***

Date of examination: _____ ☐ Essentially normal ☐ Abnormalities as follows: _____

_____

ASSESSMENT: LIMITATIONS OR HEALTH CONCERNS, INCLUDING ALLERGIES, MEDICATIONS, AND DIETARY RESTRICTIONS

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.? ☐ 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? _____

_____

Other limitations or health concerns:_____

_____

_____

IMMUNIZATIONS: ***Please include an *updated copy* of the immunization record with this form***

IMMUNIZATIONS:

Complete for Age ☐ YES ☐ NO

In Process ☐ YES ☐ NO

Explain: _____

EXEMPT FROM IMMUNIZATION:

Religious Conviction ☐ YES ☐ NO Health ☐ YES ☐ NO Other _____

***Per Sec. 3313.671 of the Ohio Revised Code an immunization waiver form must be completed for all exemptions**

MEDICAL STATEMENT VERIFICATION

This child has been examined and is in suitable condition to participate in group care.

PLEASE PRINT OR STAMP

Healthcare provider name:	**Healthcare provider signature**:
Address	
Phone	Date signed