

MUST BE FILLED OUT COMPLETELY

Immaculate Heart of Mary School

Health Form

Physical Assessment

Grade/Homeroom _____

Year Enrolled _____

Child's Name	Gender	Age	Birthdate
Parent/Guardian	Parent/Guardian Address	Home Phone Number	

Objective Data

Height	Weight	Blood Pressure	Pulse
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Immunization Record					
Type	Date (MUST include month/date/year)				
DTaP DPT or DT					
DT/Td					
Polio					
MMR					
Hepatitis B					
Varicella					
HIB					
Tuberculin Test					
Rotavirus					
Other					

Screening Tests

Vision	Date	Hearing	Date
Per ODH: pass line is 20/30;each eye		Pure Tone Testing: Per ODH@	
Distance Acuity	Right _____ Left _____	20 decibels;1000,2000,4000 Hz	
Farsightedness	Pass _____ Fail _____	Right Ear	Pass _____ Fail _____
Muscle Balance	Pass _____ Fail _____	Left Ear	Pass _____ Fail _____
Color Deficit?	Pass _____ Fail _____	Child wears hearing aid?	Yes _____ No _____
Stereopsis	Pass _____ Fail _____	Tested with hearing aid?	Yes _____ No _____
Child Wears Glasses?	Yes _____ No _____	Referral Made?	Yes _____ No _____
Tested with glasses?	Yes _____ No _____	Other test(specify) _____	
Referral Made?	Yes _____ No _____		
Specify Test Equipment	_____		

Speech Assessment

___ Child has no discernible speech problem

___ Child has possible problem with: ___ Articulation ___ Rhythm ___ Voice ___ Language

Speech evaluation is recommended: ___ Yes ___ No

Allergies (Please list and describe allergies or reactions)

Medication/Drugs
Foods/Plants/Animals/Other
Recommended treatment if allergy is severe(life threatening allergies require an IHP)

Injuries, Illness & Hospitalization

Injuries/Illness/ Hospitalizations	Age	Please explain

Medications	Name	Dose & Frequency	What is Medication For?

Activities & Limitations

Does this child have any physical, developmental or behavioral problems? Suggest special programs, placement or attention that the school can provide.

Can the child participate fully in the following activities :

Classroom and academic activities Yes No
 Physical education classes Yes No
 Competitive Athletics Yes No
 Contact & collision sports Yes No

Specify any limitations:

This child is essentially within normal limits? Yes No- Explain:

Physical Examination (Must be within the last 12 months)

Date of Examination: _____

Physician Signature: _____

Physician's Printed Name _____

Address _____

Phone Number _____

