

# HAMILTON LOCAL SCHOOLS

775 Rathmell Rd., Columbus, OH 43207

## SCHOOL HEALTH EXAMINATION FORM

*Please Print*

**Child's Name:** \_\_\_\_\_ **Birth date:** \_\_\_\_\_  
(first name) (middle name) (last name)

**Home Address:** \_\_\_\_\_ **Home Phone:** \_\_\_\_\_

**Mother's Name:** \_\_\_\_\_ **Place of Employment:** \_\_\_\_\_ **Business Phone:** \_\_\_\_\_

**Father's Name:** \_\_\_\_\_ **Place of Employment:** \_\_\_\_\_ **Business Phone:** \_\_\_\_\_

**Physician's Name:** \_\_\_\_\_ **Address:** \_\_\_\_\_ **Office Phone:** \_\_\_\_\_

1. Is there anything about your child the teacher or school needs to know to understand him/her better?

2. List diseases, serious illnesses, surgeries, injuries, or health conditions your child has had along with the dates (year only.)

3. Does any relative or anyone in the home have Tuberculosis, Diabetes, or other illnesses? If yes, describe.

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### IMMUNIZATIONS

Date: month / day / year

DPT				
TD				
POLIO				
MMR				
HIB				
HEP. B				
CH. POX				
OTHER				

### VISION SCREENING TESTS

	Right	Left
Muscle Balance		
Farsightedness		
Color		
Distance Acuity		

### HEARING SCREENING TESTS

Right \_\_\_\_\_ Left \_\_\_\_\_

### TUBERCULIN

Date: \_\_\_\_\_

COMMENTS:

### PHYSICAL ASSESSMENT

Check one:

\_\_\_\_\_ Entirely within normal limits

\_\_\_\_\_ Abnormalities as follows:

Is there any reason why the student cannot carry out a full program of school work?

\_\_\_\_\_ NO \_\_\_\_\_ YES

If YES, please explain:

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date