West Clermont Local School District
Health Record

Exam Date _____

Child's Legal Name _____ Date of Birth _____
Parent/Guardian's Name _____ Sex: ☐ Male ☐ Female Age _____
Address _____ Home Phone _____
_____ Work Phone _____
Elementary School _____ Cell Phone / Pager _____

******** DOCTOR TO COMPLETE FROM HERE DOWN ********

Medicine / Food Allergies _____ EpiPen Needed? ☐ Yes ☐ No
Chronic Medical Problems / Past Surgeries _____
Medications Taken _____

PHYSICAL EXAM

Height _____ in. (_____ %) (No shoes, nearest 1/4 in.) Weight _____ lbs. (_____ %) (Light clothing, nearest 1/4 lb.) B/P _____

_____ General Appearance	_____ Nose	_____ Neck	_____ Lungs	_____ Skeletal System
_____ Eyes	_____ Throat	_____ Lymph Nodes	_____ Abdomen	_____ Neuro Muscular
_____ Ears	_____ Teeth	_____ Heart	_____ Genitalia	_____ Skin

Abnormal exam findings _____

_____

IMMUNIZATIONS

TYPE	DATE (MO/DA/YR)				
DTaP					
Tdap					
POLIO					
HIB					
HEPATITIS B					
MMR					
VARICELLA					
OTHER					

LABORATORY TESTS
(optional)

Hb. / Hct. _____
Lead Level _____
Urine glucose _____
Urine protein _____
Urine blood _____
TB Mantoux _____
Other _____

SPEECH AND LANGUAGE

Speech Assessment:	☐ Child has no discernable speech problem ☐ Speech screen not done
Child has possible problem with:	☐ None ☐ Articulation ☐ Rhythm ☐ Voice ☐ Language
Formal speech evaluation recommended?	☐ No ☐ Yes

HEARING

DATE MO/DA/YR	AUDIOMETRY RESULTS (Pass/Fail)		OTHER TESTS (Specify)		REFERRED TO / MANAGED BY
	R	L	R	L	
	☐ Pass ☐ Fail	☐ Pass ☐ Fail			

VISION

DATE MO/DA/YR	DISTANCE ACUITY Circle one: corrected uncorrected		STRABISMUS		REFERRED TO / MANAGED BY
	R	L	R	L	
	20/	20/			

This child is able to participate in the following: ☐ Classroom and academic activities ☐ Competitive athletics ☐ Physical education classes ☐ Contact and collision sports

Describe any concerns, limitations, or recommendations to the school: _____

_____

(Office / Doctor's Address Stamp Here)

Physician's Signature: _____

Date: _____