Early Childhood Physical Form

Release: I give permission for my physician's office to fax/send this completed form to

_____ _____
(School) _____
_____ _____
(Fax Number) *(Address)*

*Signature of parent or legal guardian*_____ *date:*_____

Child's name: _____ Date of Birth:_____
Parent's name: _____ Age: _____
Address: _____ Date of Exam: _____
_____

Birth History:

Was your child born early, late, or on time?_____
Birth Weight? _____
Medication's used during pregnancy?_____
_____
_____

Medical History:

Are there any medication or food allergies? _____ If so please list_____
_____
List any medical problems or diseases your child has/had: _____
_____
List any surgeries, hospitalizations, serious injuries, or broken bones:_____
_____
Please list any medical problems that run in the immediate family:_____
_____
List any problem behaviors you child has exhibited in the past year._____
_____

Physical Exam:

* indicates critical areas required by state law

*Height _____
*Weight_____
Blood Pressure_____
*Hematacrit_____
*Lead_____
*Hearing: Right: Pass/ Fail
Left: Pass/Fail
*Vision: Right: Pass/Fail
Left: Pass/Fail

Concerns:

_____
_____
_____

Concerns/Recommendations:

_____
_____
_____

Head _____ Abdomen _____
Eyes _____ Genitalia _____
Ears _____ Extremities _____
Nose _____ Spine/Neck _____
Throat _____ Dental _____
Neurological _____ Skin _____
Neck/Thyroid _____ Speech _____
Heart _____ Lungs _____
Development _____

*Immunization Record:
Please indicate month/date/year of each immunization

DTP 1_____2_____3_____4_____5**_____
POLIO 1_____2_____3_____4**_____
MMR 1_____
HIB 1_____
**the 5th DTP and 4th POLIO should be administered just prior to preschool or school entrance.
****

_____ Student has had the immunizations required by section 3313.671 of the Ohio Revised Code for the admission to school, or has had the immunizations required by the Ohio Department of Health for infants and toddlers, or
_____ is to be exempted from these requirements for medical or religious reasons.

_____ Student is free from apparent communicable disease and is in suitable condition to attend a preschool program based upon his/her medical history and physical condition at the time of this examination.

Physician's Signature: _____

Date of Signature: _____

Physician's Name (Please Print) _____

Address: _____
_____

Phone: _____