HIGHLAND PRESCHOOL

PHYSICAL EXAMINATION for 2018-2019
*State Law Requires That This Form Be Filled Out Every Year by a Physician

Child's Name _____ D.O.B. ___ /___ /___ Source of Payment _____

SECTION 1 – PHYSICAL ASSESSMENT

Did the examination reveal any abnormalities in the following areas?

General Appearance	YES ( ) NO ( )
Skin	YES ( ) NO ( )
Lymph nodes	YES ( ) NO ( )
Eyes	YES ( ) NO ( )
Ears	YES ( ) NO ( )
Nose, Throat	YES ( ) NO ( )
Teeth Gums, Tongue, Palate	YES ( ) NO ( )
Heart	YES ( ) NO ( )
Lungs	YES ( ) NO ( )
Abdomen	YES ( ) NO ( )
Genitalia	YES ( ) NO ( )
Skeletal System	YES ( ) NO ( )
Neuro Muscular	YES ( ) NO ( )
Allergies	YES ( ) NO ( )
Other	YES ( ) NO ( )

SECTION 2 – SCREENINGS

***Visual Acuity _____**

***Hematocrit or Hgh _____ *Lead _____**

***Height _____ *Weight _____**

***Speech _____ *Hearing _____**

Urinalysis _____ Blood Pressure _____

Sickle Cell Anemia _____

Abnormal Handicapping Condition: _____

Medications: _____
Dosage Purpose

***Required screenings**

SECTION 3 – IMMUNIZATION – Please review documentation provided by parent/guardian and complete this record

Immunization	Date	Date	Date	Date	Date	Date	Comments
DPT							
OT							
IPV							
MMR							
HIBS							
Hepatitis B							
Varicella							
TB Test							

MEDICAL HISTORY

___ Asthma ___ Cystic Fibrosis ___ Ear infection, recurrent ___ Meningitis ___ Tuberculosis

___ Blind ___ Deaf ___ Eczema ___ Seizure Disorder ___ Chicken Pox

___ Diabetes ___ Heart Disease ___ Sickle Cell Anemia ___ Other

PLEASE IDENTIFY ANY SIGNIFICANT CONCERNS:

Neurologic Orthopedic

Seizures (Type & Frequency) Dietary

Allergies Other

RESTRICTIONS:

RELEVANT FINDINGS:

This is to certify that I have examined _____ on ___/___/___ and have found that this child:
Child's Name

1. Has had the immunization required by Section 3313.671 of the revised code for admission to school, or has had the immunizations required by the State Department of Health for Infants and Toddlers, or is to be exempted from these requirements for medical reasons.
2. And based upon his/her medical history and physical condition at the time of this examination, is free from apparent communicable disease and is in suitable condition for enrollment in a child day care and/or preschool facility.

Physician's Signature _____ Telephone Number _____

Street Address _____ City, State, Zip _____ _