

PHYSICIAN REPORT

Early Childhood Education

WHEN COMPLETED PLEASE FORWARD TO:

MADDUX-LANG PRIMARY SCHOOL

4010 Crains Run Road, Miamisburg, OH 45342

(937) 847-2766 * FAX (937) 847-8349

Name _____ DOB: _____ Sex: ___ M ___ F

Height: _____ Weight: _____ BP: _____ Pulse: _____ Respiration: _____

Eyes: _____ Vision: Right _____ Left _____

Ears: _____ Hearing Screening: _____

Dental (condition): _____ Throat: _____ Nose: _____

Has the child been referred to a dentist? _____

Chest: _____

Complete Immunization Record

Heart: _____

DPT: PLEASE ATTACH COMPLETE

Abdomen: _____ Hernia: _____

Polio*: IMMUNIZATION RECORD

*Indicate OPV or IPV

Genital Development: _____

MMR: _____

Orthopedic Finding: _____

Hib: _____

Neurological Findings: _____

Hepatitis B: _____

Seizures – type & frequency: _____

Chicken Pox: _____

TB Skin Test: _____

Lead Level: _____ Hematocrit: _____

Current Medications:

Allergies: _____

Significant Medical History:

Diagnosis:

Atlantoaxial Instability X-Ray (*Down Syndrome Only*): ___ Done ___ Not Done ___ Positive ___ Negative

Date: _____

I certify that no communicable disease is evident at the time of this examination.

Date of physical

Physician's Signature

Address & Telephone