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: ____________________

Heart: ____________________

Abdomen: _________ **Hernia:** ________

Genital Development: ______________

Orthopedic Finding: ______________

____

Neurological Findings: ______________

____

Seizures – type & frequency: ______________

Complete Immunization Record

DPT: ____PLEASE ATTACH COMPLETE_____

Polio*: ___ IMMUNIZATION RECORD______

***Indicate OPV or IPV**

MMR: ____________________

Hib: ____________________

Hepatitis B: ____________________

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**