SHELBY CITY SCHOOlS' LITTLE WHIPPETS PRESCHOOL PROGRAM

PHYSICAL EXAMINATION

*State Law Requires That This Form Be Filled Out Every Year

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	Date
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 (Types & 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 No._____________________________

Street Address_____________________________________ City, State, Zip____