

ST. MARY PRESCHOOL PROGRAM

PHYSICAL EXAMINATION FORM

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

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 () **Speech **Hearing ** **Hearing ** **Hearing ** **Blood Pressure ** Urinalysis ** Blood Pressure ** ** ** ** ** ** ** ** ** **	Child's Name	D.C	D.B/_	/	Sou	rce of Payment_			
General Appearance				SECTION 2- SCREENINGS					
Skin YES NO ()	In the following areas?			*V	isual <i>A</i>	Acuity			
Section 3 - Immunization Date D								*Lead	
Specific Commons Specific Co	Lymph Nodes YES	YES () NO ()		*H	*Height		*Weig	*Weight	
Teeth, Gums, Tongue, Palate YES () NO ()	ars YES () NO ()			*S	*Speech *Hearing		ing		
Abdomen YES () NO () Genitalia YES () NO () Skeletal System YES () NO () Neuro Muscular YES () NO () Neuro Muscular YES () NO () Other YES () NO () Other YES () NO () Other YES () NO () SECTION 3 – IMMUNIZATION – Please review documentation provided by parent/guardian and complete this record Immunization Date Date Date Date Date Date Date Date	Teeth, Gums, Tongue, Palate YES () NO ()			Ur	Urinalysis Blood Pressure				
Skeletal System YES () NO () Allergies YES () NO () Allergies YES () NO () Allergies YES () NO () **Required Screenings* **Required Screenings* **SECTION 3 – IMMUNIZATION – Please review documentation provided by parent/guardian and complete this record Immunization Date Date Date Date Date Date Date Date	Lungs YES () NO ()			Sickle Cell Anemia					
Allergies YES () NO () The vest of the	Skeletal System YES	etal System YES () NO ()			Abnormal Handicapping Condition:				
*Required Screenings SECTION 3 – IMMUNIZATION – Please review documentation provided by parent/guardian and complete this record Immunization Date Date Date Date Date Date Date Date				Me	Medications:				
SECTION 3 - IMMUNIZATION - Please review documentation provided by parent/guardian and complete this record Immunization Date D	Other YES	() NO ()							
Immunization Date									
DPT OT OT IPY MMR HIBS Hepatitis B Varicella TB Test MEDICAL HISTORY Asthma			-		ent/g	l			
IPV		Dute 1	Dute	Date		Dute	Date	Dute	
MMR HIBS Hepatitis B Varicella TB Test MEDICAL HISTORY AsthmaCystic FibrosisEar Infection, recurrentMeningitisTuberculosis									
HIBS Hepatitis B Varicella TB Test MEDICAL HISTORY Asthma	IPV								
HIBS Hepatitis B Varicella TB Test MEDICAL HISTORY Asthma	MMR								
Hepatitis B									
Varicella									
MEDICAL HISTORY Asthma									
Asthma									
BlindDeafEczemaSeizure DisorderChicken Pox	MEDICAL HISTORY								
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 on on on 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.	AsthmaCystic Fibrosis	Ear Infection	on, recurren	nt		•		ılosis	
PLEASE IDENTIFY ANY SIGNIFICANT CONCERNS: NeurologicOrthopedicSeizures (Types & Frequency) DietaryAllergiesOther RESTRICTIONSRELEVANT FINDINGS This is to certify that I have examinedon/ 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.							Pox		
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DietaryAllergiesOther RESTRICTIONSRELEVANT FINDINGS This is to certify that I have examinedon	PLEASE IDENTIFY ANY SIGNIFICANT	T CONCERNS:							
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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.	 Has had the immunization rec 	quired by Section 3313.67	71 of the rev	vised code fo	or adm	nission to school or	has had the immu	nizations required	
Physician's Signature Telephone No	2. And based upon his/her medi	cal history and physical co	ondition at t	the time of t	his exa	amination, is free fr			
	Physician's Signature		Teleph	one No					

Street Address______City, State, Zip_____