PHYSICAL EXAMINATION – EARLY CHILDHOOD EDUCATION

Child's Name: Phone: Source of Payment

Parents Name: Address:

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: Yes ☐ No ☐
Tongue and Palate: Yes ☐ No ☐
Heart: Yes ☐ No ☐
Lungs: Yes ☐ No ☐
Abdomen: Yes ☐ No ☐
Genitalia: Yes ☐ No ☐
Skeletal System: Yes ☐ No ☐
Neuro Muscular: Yes ☐ No ☐

Abnormal/Handicapping Conditions

Specify Asthma/Allergies

Medications Prescribed

Section 2 - Screenings

Please indicate results of any screenings:

	DATE	RESULTS	FOLLOW-UP
Dental			
Visual Acuity			
Lead Level			
Hemoglobin			
Height			
Sickle Cell Anemia			
Blood Pressure			
Audiogram			
Speech			

Section 3 - IMMUNIZATION

Please review documentation provided by parent or guardian and complete this record.

IMMUNIZATION	DATE #1	DATE #2	DATE #3	DATE #4	DATE #5	COMMENTS
DTP/DTaP/DT						
OPV/IPV						
MMR						
Hib						
HEPATITIS B						
VARICELLA						
PREVNAR						

Impression:

Plan:

Is this a HealthCheck Physical Exam? Yes ☐ No ☐

CHILD'S MEDICAL STATEMENT

This is to certify that I have examined the above named child on (date)_____found that this child:

1) Has had 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 ☐, religious ☐, other_____
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 facility.

Physician's Signature	Child's Birthdate
Street Address	
City, State, Zip / Telephone	