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