Preschool Physician Report

REV. 01/25/16 Springboro

Child's Name (print or type)		Date of Birth (MM/DD/YYYY)
Date of Exam (MM/DD/YYYY)	Height	Weight
Name of Physician/Physician's Assistant/Advanced Practice Nurse/Certified Nurse Practitioner		Telephone Number
Street Address		
City, State, and Zip Code		

Physical Examination

Essentially Normal: Yes No If no, please enter abnormalities in the Physician's assessment summary.
Please specify allergy (if applicable) Food _____ Medication _____ Other _____
Physician Ordered Treatment includes (circle) Epinephrine Auto-injector Antihistamine Multi Dose Inhaler

Immunization Information

Diseases for Immunization	PHYSICIAN/PHYSICIAN'S ASSISTANT/ADVANCED PRACTICE NURSE/CERTIFIED NURSE PRACTIONER COMPLETES Check all that apply for each disease		
	Immunized	**In Process of Immunization**	**Medically Contraindicated/ Not Age Appropriate**
DPT	☐	☐	☐
MMR	☐	☐	☐
HEPATITIS A	☐	☐	☐
HEPATITIS B	☐	☐	☐
POLIO	☐	☐	☐
VARICELLA	☐	☐	☐
VARICELLA Date of Disease	☐	☐	☐
HIB	☐	☐	☐
Influenza ☐ Seasonal Vaccine Not Available	☐	☐	☐
PNEUMOCOCCAL DISEASE	☐	☐	☐
TB Test/Result	☐	☐	☐

☐ I have declined to have my child immunized against one or more of the diseases required by 5104.014 of the Ohio Revised Code. Initial beside the disease(s) being declined above and sign below.

Signature of Parent:	Date of Signature (MM/DD/YYYY)

Is the Child able to participate fully in (circle):

Classroom and academic activities? Y N

Physical Education Classes? Y N

Competition Athletics? Y N

Contact and collision sports? Y N

If the Child has any physical, developmental, or behavioral problems, how should the school plan to assist with special programs, placement, or attention?

_____
_____
_____
_____
_____
_____
_____

Physician's Assessment Summary

Problems:	**Recommendations:**

The following requirements apply to children enrolled in an Early Childhood Education Grant Program or Preschool Special Education Program:

Assessment/Screening	Completed (circle response)		Date of Completion	Reason Not Completed (religious conviction, insurance coverage, physical determination)
Vision	YES	NO		
Hearing	YES	NO		
Dental	YES	NO		
Lead	YES	NO		
Hemoglobin/HCT	YES	NO		

Physician Signature: _____ Date: _____

ATTACH A COPY OF THE CHILD'S IMMUNIZATION RECORD WITH DATES AND DOSES OF ALL IMMUNIZATIONS