

UNION COUNTY BOARD OF DD

HAROLD LEWIS CENTER

1280 Charles Lane
Marysville, Ohio 43040
Phone (937) 645-6714 Fax (937) 642-9909

CHILD ENROLLEE MEDICAL REPORT – 2017-2018

Name: _____ Date of Birth: _____

Telephone: _____ Sex: Male Female

Address: _____

Family Contact: _____ Telephone: _____

*** STATE MANDATED REQUIREMENT**

* Hematocrit level: _____

* Lead level: _____

MEDICAL INFORMATION:

Height: _____ Dental Examination: _____

Weight: _____ Heart: _____

Blood Pressure: _____ Lungs: _____

Eyes: Visual Acuity: _____ Abdomen: _____

Ears: Hearing Acuity: _____ Genitalia: _____

Hernia: _____ Speech: _____

CURRENT IMMUNIZATIONS: (PLEASE NOTE THE CHANGE IN PRE-SCHOOL RECOMMENDED IMMUNIZATIONS)

	Date	Date	Date	Date
DPT				
DTaP				
HIB				
POLIO				
MMR				
HEPATITIS B				
Influenza				
PREVNAR				
TETANUS				
TB		Reaction:		Reaction:
VARICELLA			CHICKENPOX	

IS PRE-SCHOOL SERIES COMPLETED? YES OR NO
 IF PRE-SCHOOL SERIES IS NOT COMPLETED, WHY? MEDICALLY CONTRAINDICATED
 NOT MEDICALLY APPROPRIATE FOR THE AGE OF THE CHILD
 PARENT/GUARDIAN DECLINED FOR REASON OF CONSCIENCE, INCLUDING RELIGIOUS CONVICTIONS (PARENTS MUST SIGN WAIVER FROM SCHOOL)

(OVER)

CAUSE OF DEVELOPMENTAL DISABILITY IF KNOWN:

PAST HISTORY:

CHRONIC MEDICAL
CONDITION:

(Diagnoses)

ALLERGIES:

(Food/Medications)

SEIZURES:

SURGERIES:

CURRENT LIST OF MEDICATIONS:

Medications needed while at school: YES (Please request and Authorization to Administer Medication form from school) OR NO

Name of Medication

Dosage

Purpose

PHYSICAL RESTRICTIONS, IF ANY:

DIETARY RESTRICTIONS, IF ANY:

DATE OF EXAMINATION: _____

Physician's Signature

Physician's Name (Please Print or Type)

Date

Address

Phone Number

City, State, Zip Code