***** THIS FORM MUST BE COMPLETED, SIGNED, AND DATED BY A PHYSICIAN

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

CHILD ENROLLEE MEDICAL REPORT – 2019 - 2020

Name: _____ Date of Birth: _____

Telephone: _____ Sex: ❑ Male ❑ Female

Address: _____

Family Contact: _____ Telephone: _____

*** Last results if known/date***	
* **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
DT/ DTaP				
POLIO				
MMR				
HIB				
HEPATITIS B				
VARICELLA			CHICKENPOX:	
HEPATITIS A				
PNEUMOCOCCAL				
ROTAVIRUS				
INFLUENZA				

IS PRE-SCHOOL SERIES COMPLETED? ❑ **YES** **OR** ❑ **NO**

IF PRE-SCHOOL SERIES IS NOT COMPLETED, WHY? ❑ **MEDICALY CONTRAINDICATED**
❑ **NOT MEDICALLY APPRPORIATE 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