Vandalia Butler City Schools
Preschool Physician Report Form
Demmitt Elementary
1010 East National Road
Vandalia, Ohio 45377
(937) 415-6500
Fax: (937) 415-6538

Name_____ DOB:_____ Sex:_____M _____F

Height:_____(____%) Weight_____(____%) BP_____ Pulse_____ Respiration_____
Heart_____ Head_____ Eyes_____ Ears_____ Nose_____
Teeth_____ Neck_____ Chest_____ Lymphatics_____ Back_____
Abdomen_____ Genitalia _____ Extremities_____ Neurological_____
Orthopedics_____ Oral Motor/Eating/Feeding_____
☐ No significant findings were noted during general physical exam.
☐ Significant findings were noted during general physical exam. Please specify:_____

ALLERGIES:_____

Medications: Child takes prescribed medication on regular basis? ☐ No ☐ Yes

Medication	Dosage	Prescribed for:
1.		
2.		
3.		

Required by Law

Blood Lead screening Date:_____ Results:_____ Hematocrit test Date:_____ Results:_____%

Vision (Check all that applies)
☐ Within Normal Limits Yes/No (If not, specify: _____)
☐ Wears Corrective Lenses Yes/No
☐ Eye Surgery Yes/No (Specify:_____)

Hearing (Check all that applies)
☐ Within Normal Limits Yes/No (If not, specify: _____)
☐ History of Frequent Ear Infections Yes/No
☐ PE Tubes Inserted Yes/No (Date:_____)

Diagnosed Disorders/Syndromes (Check all that apply)
☐ Diabetes
☐ Down Syndrome Atlantoaxial Instability X-Ray: ☐ Completed (☐ Positive ☐ Negative) ☐ Not Completed
☐ Seizure Disorder (Specify Type and Frequency:_____)
☐ Cerebral Palsy (Specify Impact:_____)
☐ Pervasive Developmental Disorder (Specify:_____)
☐ Mental Health Disorder(s)
(Specify:_____) ☐ Other_____

Behavioral Concerns
☐ Hyperactivity ☐ Distracted ☐ Short Attention Span ☐ Withdrawn ☐ Aggression ☐ Anxiety ☐ Other
(Specify:_____)

Immunizations		Ohio Law Requires		Dates of Immunizations Must include month/day/year	
DtaP, DTP or DT (Pediatric)	4 Doses				
Polio Vaccine	3 Doses				
HIB*	3 or 4 Doses				
Hepatitis B**	3 Doses				
Varicella	1 Dose				
MMR	1 Dose				
Hep A	2 Doses				
Pneumococcal	4 Doses				
Influenza	1 Dose yearly				
Measles If	1 Dose				
Mumps Given	1 Dose				
Rubella Separate	1 Dose				

I certify that no communicable disease is evident at the time of this examination and the child may attend a preschool program.

Physician's Signature (MD,DO, or NP)

Date_____