Logan County Board of DD
Discovery Center/ Public Preschool/Early Childhood
1973 State Route 47 West
PO Box 710
Bellefontaine, Ohio 43311
Phone: 937-592-2009 **Fax: 937-592-3098**

MEDICAL FOR ENROLLMENT

(To be completed by Physician)

Name of Enrollee_____ D.O.B._____ Sex_____

IMMUNIZATIONS (given – month/day/year) OR ☐ See attachment
Required for enrollment
DPaT (1) _____ (2)_____ (3)_____ (4)_____ (5)_____
Polio (1)_____ (2)_____ (3)_____ (4)_____
Chicken pox (varicella) (1)_____(2)_____
MMR (1)_____ (2)_____
HiB (1)_____ (2)_____ (3)_____ (4)_____
Hepatitis B (1)_____ (2)_____ (3)_____
Other non-required immunizations: Hepatitis A (1)_____ (2)_____

PHYSICAL ASSESSMENT
Height _____ Weight _____ Head Circumference _____
Heart Rate: _____ Respiration Rate: _____ Blood Pressure: _____
Visual Screening: Acuity Vision: Rt. _____ **L.** _____
Vision ☐ No deficits at present time ☐ Further screening recommended
Hearing Screening: Rt. _____ **L.** _____Tubes: Rt. _____ L. _____
Hearing ☐ No deficits at present time ☐ Further screening recommended

General Appearance	☐ Normal	☐ Abnormal _____
Nutrition	☐ Normal	☐ Abnormal _____
Head	☐ Normal	☐ Abnormal _____
Skin	☐ Normal	☐ Abnormal _____
Lymph Nodes	☐ Normal	☐ Abnormal _____
Eyes	☐ Normal	☐ Abnormal _____
Ears	☐ Normal	☐ Abnormal _____
Nose/Throat	☐ Normal	☐ Abnormal _____
Teeth, Gums	☐ Normal	☐ Abnormal _____
Tongue, Palate	☐ Normal	☐ Abnormal _____
Heart BP_____	☐ Normal	☐ Abnormal _____
Lungs	☐ Normal	☐ Abnormal _____
Abdomen	☐ Normal	☐ Abnormal _____
Genitalia	☐ Normal	☐ Abnormal _____
Skeletal System	☐ Normal	☐ Abnormal _____
Neuro Muscular	☐ Normal	☐ Abnormal _____

Please Indicate Results of Any Screenings

(Date - Results - Follow-Up)

1) Hct/Hgb_____
2) Lead_____
3) TB_____
4) Urinalysis_____
5) Atlanto-Axial_____
6) Sickle Cell_____
7) EEG, EKG, X-ray _____

Orthopedic braces/appliances: _____
Ostomy devices: _____ Other: _____
Positive neurological findings: _____
Atypical Behavior: _____ Emotional Concerns: _____
Frequency and type of seizures, if any: _____

PREVIOUS DISEASES (Please check):

_____ Measles	_____ Diphtheria	_____ Rheumatic Fever
_____German Measles	_____ Polio	_____ Pneumonia
_____ Chicken Pox	_____ Heart Disease	_____ Tuberculosis
_____ Mumps	_____ Diabetes	_____ Meningitis
_____Whooping Cough	_____ Repeated Tonsillitis	_____ Nephrititis
_____ Scarlet Fever	_____ Asthma	
_____ Repeated Respiratory Infections		

Other serious illnesses: _____
Injuries: _____
Hospitalization (reason, dates): _____

ALLERGIES: Food, Medication, Insect, Other

Medication:_____ Type of reaction:_____

_____

Food:_____ Type of reaction:_____

_____

Insect & Other:_____ Type of reaction:_____

_____

DIET RESTRICTIONS: _____

_____

MEDICATIONS: Name, purpose, when given _____

_____

_____

If medication is required at school, please contact the school nurse at 937-292-3060

DIAGNOSIS to include any handicapping conditions: _____

_____

_____ Etiology (if known) _____

Is there contraindication to any physical activities? YES _____ NO _____

If yes, please explain: _____

_____

This is to certify that I have examined the aforesaid patient and have found that he/she has had the immunizations required by the Ohio Department of Health for children, or is to be exempted from these requirements for medical or religious reasons. *I understand a completed exemption form is required annually.* I have also found that he/she is free from apparent communicable disease and is in suitable condition to participate in any Discovery Center program, based on his/her medical history and physical condition at the time of this examination.

_____

Physician's Name (PLEASE PRINT or TYPE)

_____

Physician's Signature (Required)

_____

Phone Number

_____

Date

Physician's Stamp

Date_____

PLEASE RETURN TO:

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