CHILD PHYSICAL EXAMINATION RECORD

****** All Sections Must Be Completed ******

CHILD'S NAME			BIRTHDATE
Height inches	Weight lbs.	B/P	TEMP.
Hematocrit or Hemoglobin **REQUIRED ANNUALLY**	**If Hgb<11.0 or Hct<34%, has treatment been prescribed: YES / NO** If yes, please describe treatment:		
LEAD SCREEN RESUTS _____ (please give number) **Child must have one passing lead screening. Screenings of 10 or greater must be repeated. DATE OF SCREENING Lead screening done by: Health Department / Other (Annual lead screening is not required.)			
ALLERGIES (Includes allergies to Medications, Foods and Others.)			
SIGNIFICANT MEDICAL HISTORY			
Is child currently taking Medication? Yes / No If yes, What Medication(s)?			

IMMUNIZATIONS					
DPT / OPT / DTaP diphtheria / tetanus / pertussis					
Polio (OPV / IPV)					
MMR measles / mumps / rubella			**Two (2) MMR immunizations are now required for kindergarten.**		
HIB haemophilus B influenza					
Hep B or HBV hepatitis B vaccine				**Hep B series required for Kindergarten**	
Varicella (Varivax) chicken pox vaccine			If not given, has child had Chicken Pox? Yes / No Date: (please circle one)		
Pneumonia (Prevnar)			Give name of immunization and date(s) given		
Other immunizations	Give name of immunization and date(s) given				
TB test (tuberculosis test)	Date:	**Positive / Negative** (please circle one)	Comments:		

SCREENINGS ***CHILD ONLY NEEDS TO BE SCREENED. THEY DO NOT NEED TO BE TESTED***				
VISION SCREENING	**NORMAL/ABNORMAL** (please circle one)	**CORRECTED / UNCORRECTED** (please circle one)	**ACUITY** R _____ L _____	**STRABISMUS POSITIVE / NEGATIVE** (please circle one)
Does the child need to be seen by an Eye Doctor? Yes / No Is the child currently under the care of an Eye Doctor: Yes / No		Vision Comments:		
HEARING SCREENING	Pass _____ Fail _____	Hearing Comments:		
SPEECH SCREENING	Pass _____ Fail _____	Speech Comments:		

PHYSICAL EVALUATION		**NORMAL**	**ABNORMAL**	**COMMENTS** (explain all abnormal observations)
1. GENERAL APPEARANCE				
2. EARS:	a. canals			
	b. TM			
3. NOSE:	a. septum or obstruction			
	b. discharge			

PHYSICAL EVALUATION CONT.		NORMAL	ABNORMAL	COMMENTS (explain all abnormal observations)
4. DENTAL / MOUTH:	a. teeth			
	b. pharynx			
	c. tonsils			
5. LUNGS / THORAX:	a. contour			
	b. breath sounds			
6. HEART	a. rate			(Please thoroughly explain all murmurs.)
	b. rhythm			
	c. murmur	(no)	(yes)	If a hear murmur is present, does child have activity restrictions? Yes / No
7. LYMPH NODES:				
8. ABDOMENT (include hernia):				
9. SPINE:				
10. EXTREMITIES:				
11. GENITALIA:				
12. NEUROLOGICAL:	a. gait			
	b. strength			
	c. coordination			
	d. balance			
13. MENTAL STATUS:				
14. BEHAVIOR:		Appropriate	Inappropriate	(Please thoroughly explain inappropriate behavior.)

ARE THERE ANY RESTRICTIONS ON THIS CHILD'S ACTIVITIES? YES _____ NO _____	List any restrictions or health conditions _____ _____ _____

DOES THIS CHILD NEED ANY MEDICAL FOLLOW-UP CARE? YES _____ NO _____	If yes, what care is indicated? _____ _____ Date of appointment for follow-up: _____

Based upon medical history and physical condition at the time of this examination, this child is in suitable condition for participation in group care. As required by Rules 5101:2-12-37 and 5101-13-37, Ohio Department of Job and Family Services Child Care Licensing. Children enrolled in a licensed child care program are required to have a physical every 13 months.

Signature _____ Date of Physical _____

Address _____ Phone _____

_____ Fax _____

(may use office stamp for address)