LAKEWOOD CITY SCHOOLS

PHYSICIAN'S MEDICAL REPORT

Lakewood Early Childhood Program
13701 Lake Ave • Lakewood, OH 44107
Phone: 216-529-4214 Fax: 216-529-4104

Student's Name _____ Date of Birth_____

1. GENERAL HEALTH: Date of Exam_____

Height:	Weight:	BP:	Nose:
Ears:	Throat:	Tonsils:	Teeth:
Glands:	Heart:	Lungs:	Abdomen:
Skin:	Orthopedic:	Muscle Tone/Power:	Gait:
Reflexes:	Station:	Cranial Nerve:	Extremities:
Asthma:	Hearing:	Speech/Language:	
Hematocrit:	PB (Lead):	TB Test:	
Fine or Gross Motor Abnormalities:			
Allergies:			

Vision: Without Glasses: R / L	With Glasses: R / L

2. IMMUNIZATION RECORD: (Fill in dates below or attach record)

	1ST DOSE	2ND DOSE	3RD DOSE	4TH DOSE
DTaP				
Polio				
HIB				
Hepatitis B				
Varicella				
MMR				
Hepatitis A				
Influenza				
Pneumonia				

Has this child had Chicken Pox? ☐ No ☐ Yes If yes, when? _____

3. SIGNIFICANT HEALTH HISTORY: _____

_____

4. SENSORY ABNORMALITIES: Please describe: _____

5. BEHAVIORAL PROBLEMS: ☐Hyperactive ☐Withdrawn ☐Short Attention Span ☐Distracted ☐Disturbed Sleep Pattern

☐ Other (please describe) _____

6. RESTRICTIONS (if applicable): Is this child able to participate fully in: Classroom and academic activities ☐ Yes ☐ No

If limitations are advised, please specify: _____

7. LIST ALL PRESCRIBED MEDICATIONS AND FOR WHAT REASON:

_____

8. PHYSICIAN INFORMATION (PRINT OR STAMP)

Physician's Name: _____ Date: _____

Physician's Signature: _____ Phone Number: _____