EAST CLINTON LOCAL SCHOOLS
97 Astro Way, Sabina, Ohio 45169

_____New Vienna School
301 E. Church Street
New Vienna, OH 45159
Tel: 937-987-2448
Fax: 937-584-2817

_____Sabina School
246 W. Washington Street
Sabina, OH 45169
Tel: 937-584-5421
Fax: 937-584-2817

EARLY CHILDHOOD PHYSICAL FORM

Release: I give permission for my physician's office to fax/send this completed form to:

The Above Checked School

Signature of Parent of Legal Guardian _____ Date _____

Date of Exam _____

Child's Name: _____ Date of Birth _____

Parent's Name: _____

Address: _____

Birth History

Was your child born early, late or on time? _____

Birth Weight _____ Medications used during pregnancy? _____

Medical History

Are there any medication or food allergies? _____ If so, please list _____

_____

List any medical problems or diseases your child has/had _____

_____

List any Surgeries, hospitalizations, serious injuries or broken bones: _____

_____

Please list any medical problems that run in the immediate family: _____

_____

EXAM CONTINUED ON NEXT PAGE

Physical Exam: * indicates information required by state law **Concerns**

*Height _____ _____

*Weight _____ _____

Blood Pressure _____ _____

Hematocrit _____ _____

*Lead _____ _____

Concerns/Recommendations _____

_____

Hearing: Right – Pass / Fail Left – Pass / Fail

Vision: Right – Pass / Fail Left – Pass / Fail

Head _____Abdomen_____

Eyes_____Genitalia_____

Ears_____Extremities_____

Nose_____ Spine/Neck_____

Throat_____Dental_____

Neurological_____Skin_____

Neck/Thyroid_____Speech_____

Heart_____Lungs_____

Development_____

Immunization Record- Please indicate month/date/year of each immunization

DPT 1_____2_____3_____4_____5**_____

Polio 1_____2_____3_____4**_____

MMR 1_____2_____ Varicella 1_____2_____

Hep A 1_____2_____ Hep B 1_____2_____3_____

Hib 1_____2_____3_____

The 5th DTP and 4th Polio should be administered just prior to preschool or school entrance

Physician's Signature _____ Date _____

Physician's Name _____

Address _____

Phone _____