WESTLAKE City Schools

**WESTLAKE EARLY CHILDHOOD PROGRAM**
**SCHOOL ENTRANCE MEDICAL RECORD**
**TAKE THIS FORM TO YOUR PHYSICIAN TO COMPLETE**

*Office Use:*
Center Based / Itinerant
Docs_____
Case Mgn_____
Clinic _____

STUDENT NAME_____ DATE OF BIRTH_____ GENDER M / F

## LAB RESULTS / IMMUNIZATION HISTORY

MONTH, DAY AND YEAR ARE REQUIRED FOR EACH OF THE FOLLOWING DATES:

****Immunization Record Must Be Attached****

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Lead Poisoning | ☐ Date | _____ | Type | ☐ C | ☐ V | Results | _____ µg/dL |
| Hemoglobin | ☐ Date | _ | Type | ☐ C | ☐ V | Results | µg/dL |

### PHYSICAL EXAMINATION

***All sections of the form must be completed including vision and hearing screenings***

| | | |
|---|---|---|
| **DATE OF EXAM**: _____ | Eyes: _____ | Ears: _____ |
| Height: _____ | Vision: R: 20/ _____ | Hearing: Type _____ |
| Weight: _____ | L: 20/ _____ | R: _____ L: _____ |

Referred to ear or eye specialist? Yes _____ No _____

Nose: _____ Throat: _____

Mouth: _____ Teeth: _____

Is dental work indicated? Yes _____ No _____

If so, are plans being made? Yes _____ No _____

| | | | | | |
|---|---|---|---|---|---|
| Posture: | _____ | Abdomen: | _____ | Nervous System: | _____ |
| Skin: | _____ | Genitalia: | _____ | Lungs: | _____ |
| Neck: | _____ | General Condition: | _____ | Hernia: | _____ |
| Heart: | _____ | Orthopedic: | _____ | Urinalysis: | _____ |

Remarks & Recommendations: _____

Allergies (Food/Insect): _____ Recommended Treatment: _____

☐ Immunization record is attached to this form.

Physician Name (Please Print):_____Physician Signature: _____