Delphos City Schools Preschool
901 Wildcat Lane
Delphos, OH 45833
www.delphoscityschools.org
Stephanie Braun, Preschool Director
sbraun@delphoscityschools.org
419-695-1786 ext. 450
Fax: 419-692-2653

Annual Medical Diagnostic Screening Form

This form must be completed, signed and dated by a physician
This form must be provided within 30 business days of entrance into the preschool program and annually thereafter

Child's Name: _____ Date of Birth: _____

Assessments/Screenings	Assessments/Screening Completed (circle one)		Date Completed	Reason Not Completed (health professionals decision, insurance coverage, religious conviction, other)
Lead	YES	NO		
Hemoglobin	YES	NO		
Height	YES	NO		
Weight	YES	NO		

*Physician Determined

Pure Tone Hearing Screening Results

	1000	2000	4000	Observation/Comments
R	Pass _____ (20dB)	Pass _____ (20dB)	Pass _____ (20dB)	
	NonPass ____	NonPass ____	NonPass ____	
L	Pass _____ (20dB)	Pass _____ (20dB)	Pass _____ (20dB)	
	NonPass ____	NonPass ____	NonPass ____	

Evaluation Results

Diagnosis: _____

Treatment Plan: _____

Comments: _____

_____

- Continued on Reverse –

Vision Screening Results

	Corrected	Uncorrected	Type	Electronic Screener	Observation/Comments
R	Pass ____	Pass ____	Lea 5ft _____ Lea 10ft ____ Eye Check ___ Sloan Cht (10ft) ___	Suresight ____ Retinomax ____ JVAS ____	
	NonPass ____	NonPass ____			
L	Pass ____	Pass ____	Lea 5ft _____ Lea 10ft ____ Eye Check ___ Sloan Cht (10ft) ___	Suresight ____ Retinomax ____ JVAS ____	
	NonPass ____	NonPass ____			
Stereopsis	Pass ____	Fail ____	Smile (Pass 2) ____ Random Dot E ____		
Color Vision	Pass ____	NonPass ____	Ishihara – 14 plate ____ Pseudoisochromatic Color Testing – 16 plate ____ Color Vision Testing Made Easy ____		

Evaluation Results

Diagnosis: _____

Treatment Plan: _____

Comments: _____

_____

Please list any limitations or health conditions (including allergies, medications, dietary restrictions):
_____

_____

_____

This Child is free from apparent communicable disease and has received immunizations required under Section 3313.671 of the Ohio Revised Code and is in suitable condition to attend a preschool program based on his/her medical history and physical condition at the time of this examination.

_____ _____

Signature of examining Health Professional **Date of Exam**

Circle One: Physician Physician's Assistant Advanced Practice Nurse

Office Address: _____ Office Phone:
_____