Physical Exam and Medical Report

Return to: **Preschool Assessment Clinic**
1440 Lakeside Avenue
Cleveland, Ohio 44114
Phone: (216) 523-7959 Fax: (216) 592-7769

or **Your School Nurse**

Child's Name: _____ Sex: M ☐ F ☐ Race: _____ Date of Birth: ___-___-_____

Address: _____ City: _____ Zip Code: _____

Parent's/Guardian's Name: _____ Phone #: _____

Section I: Tests and Measurements

Vision Test: Date: _____ Acuity OD 20/____ OS 20/____ Strabismus: _____

Lead Results: Date: _____ PB: _____

Blood Pressure: Date: _____ Reading: _____

Hearing Test: Date: _____ dB: _____ Hz: _____ **Speech:** Normal ☐ Delayed ☐

HGB: Date: _____ Gm: _____ **HCT:** _____

Sickle Cell: Date: _____ Results: _____

Allergies: _____

_____

Section II: Medication (*include dosage and schedule)*

_____

_____

Section III: Motor Development

Normal ☐ Delayed ☐

Describe if Delayed: _____

_____

Significant medical/physical conditions that may affect school performance: _____

_____

Explain any significant behavior problems: _____

_____

Section IV: Examinations and/or Inspection

	Normal	Abnormal	Referred
Eyes	☐	☐	_____
Earns Nose Throat	☐	☐	_____
Thyroid	☐	☐	_____
Lymphatic System	☐	☐	_____
Heart Vascular System	☐	☐	_____
Lungs	☐	☐	_____
Breasts	☐	☐	_____
Abdomen	☐	☐	_____
Genitalia	☐	☐	_____
Neurological System	☐	☐	_____
Skin	☐	☐	_____
Extremities	☐	☐	_____
Spine	☐	☐	_____

Physician or Examiner's Name: *(Print)* _____ Title: _____

Examiner's Signature: _____ Date of Exam: _____-_____-_____

Clinic Address: _____ Telephone: (____) _____-_____