Midwest Regional Educational Service Center Preschool
Physical/Medical Evaluation Form

Child's Name:________________________________ Date of Birth:___________________

General Findings:
Childhood Diseases:____________________________ Chronic Illness/Hospitalization:________________________________
Allergies/Specific Precautions and/ or Treatments: ____
Current Medications/ Modified Diet:____
Height:___________________ Weight:___________________

Vision: ❑ Within Normal Limits ❑ Wears Glasses ❑ Specific Concerns:________________________________
Hearing: ❑ Within Normal Limits ❑ Hearing aids ❑ Specific Concerns:________________________________

Hemoglobin Results: ____________________ **Date** __________ **Lead Results:** _________________ **Date** ____________
Reason not completed: ❑Physician Decision ❑Religious Convictions ❑Insurance Coverage ❑Other: ________________

Communication/Speech noted concerns: ❑ Within Normal Limits ❑ Specific Concerns: ______________________
General Neurological Findings: : ❑ Within Normal Limits ❑ Specific Concerns: ____________________________
Gross Motor Skills: ❑ Within Normal Limits ❑ Specific Concerns: __________________________________
Fine Motor Skills: : ❑ Within Normal Limits ❑ Specific Concerns: __________________________________

Diagnosis: If the child has been specifically diagnosed with any of the following, please note where the evaluation took place and the date of the diagnosis.

❑ Attention Disorders:____
(Specify) (Place of Evaluation) (date)

❑ Autism Spectrum: :____
(Specify) (Place of Evaluation) (date)

❑ Mood Disorder: :____
(Specify) (Place of Evaluation) (date)

❑ Anxiety Disorder: :____
(Specify) (Place of Evaluation) (date)

❑ Neurological Impairments: :____
(Specify) (Place of Evaluation) (date)

❑ Orthopedic Impairments: :____
(Specify) (Place of Evaluation) (date)

❑ Syndromes::____
(Specify) (Place of Evaluation) (date)

Based on the medical history and physical condition at the time of this examination, the 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 for enrollment in a child care facility.

Physician's Signature: ____________________________________ **Date of Exam:**__________________

As required by Rules 5101:2-12-37 and 5101-2-13-37, the child must be examined within twelve months prior to admission.

Physician's Name:____ **Phone Number:**______________________________
Address: ____ **City, State, Zip Code:**________________________________