LAKEWOOD CITY SCHOOLS

PHYSICIAN'S MEDICAL REPORT

Lakewood Early Childhood Program
1470 Warren Rd Lakewood, OH 44107
Phone: 216-529-4214 Fax: 216-529-4104

Student's Name _____ Date of Birth_____

1. GENERAL HEALTH: Date of Exam_____

Height:	Weight:	BP:	Nose:
Ears:	Throat:	Tonsils:	Teeth:
Glands:	Heart:	Lungs:	Abdomen:
Skin:	Orthopedic:	Muscle Tone/Power:	Gait:
Reflexes:	Station:	Cranial Nerve:	Extremities:
Asthma:	Hearing:	Speech/Language:	
Hematocrit:	PB (Lead):	TB Test:	
Fine or Gross Motor Abnormalities:			
Allergies:			

Vision: Without Glasses: R / L	With Glasses: R / L

2. IMMUNIZATION RECORD: (attach record)

3. SIGNIFICANT HEALTH HISTORY: _____

_____

4. SENSORY ABNORMALITIES: _____

5. BEHAVIORAL PROBLEMS: ☼ Hyperactive ☼ Withdrawn ☼Short Attention Span ☼ Distracted

☼ Disturbed Sleep Pattern ☼ Other (please describe) _____

6. RESTRICTIONS (if applicable): Is this child able to participate fully in:

Classroom and academic activities ☼ Yes ☼ No

Please describe restrictions/limitations _____

7. LIST ALL PRESCRIBED MEDICATIONS (name/dose/frequency) AND FOR WHAT REASON:

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8. PHYSICIAN INFORMATION (PRINT OR STAMP)

Physician's Name: _____ Date _____

Physician's Signature: _____ Phone Number _____