

927 O’Bannonville Road, Loveland, OH 45140

Phone: 513-683-4757 Fax: 513-697-4191

**REPORT OF PHYSICAL EXAMINATION**

**(TO BE COMPLETED BY EXAMINING PHYSICIAN)**

Child’s Full Name Date of Birth:

 (first) (last)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **SECTION I** | Immunization | Date Given |  |  |  |  |
|  |  |  |  |  |  |  |
|  | DPT/DT |  |  |  |  |  |
|  | Polio (Trivalent) |  |  |  |  |  |
|  | Measles |  |  |  |  |  |
|  | Rubella |  |  |  |  |  |
|  | Mumps |  |  |  |  |  |
|  | HIB vaccine |  |  |  |  |  |
|  | Hepatitis B |  |  |  |  |  |
|  | Chicken Pox |  |  |  |  |  |

\*Persons objecting to immunizations please see page 2 and submit appropriate paperwork.

|  |  |  |  |
| --- | --- | --- | --- |
| **SECTION II** | Screening Test | Date Given | Results |
|  |  |  |  |
|  | Vision (distance) |  |  |
|  | Vision (color) |  |  |
|  | Hearing |  |  |
|  | Tuberculin |  |  |
|  | Hemoglobin/Hemato. |  |  |
|  | Urine |  |  |
|  | Scoliosis/Kyphosis |  |  |

|  |  |
| --- | --- |
| **SECTION III** | Physician’s Assessment |

 Entirely within normal limits Height: Weight: Abnormalities are as follows:

 Please include any remarks concerning this child’s health and your recommendations for school this coming year:

Can this child carry out a full program of school work including physical education? Yes: No:

Physician’s Name:

Office Address:

Telephone Number:

Physician’s Signature: Date of Exam:

(continued on next page)

\* Persons objecting to immunizations shall be required to submit one of the following written statements to the Children’s Meeting House Montessori School office, along with this completed physical examination form:

1. A parent or guardian’s written statement in which the parent or guardian objects to the immunization for good cause, including religious convictions.
2. A physician’s written certification that such immunization against any disease is medically contraindicated.