

Please return to:  
Clermont County Board of DD  
Thomas A. Wildey School  
P.O. Box 8  
(513) 732-7015 Voice  
(513) 732-4950 Fax

## The Thomas A. Wildey School Medical Evaluation Form

Date of medical evaluation: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

Sex: male \_\_\_\_\_ female \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Significant past medical history:(including surgeries,serious illnesses,hospitalizations)

Allergies and skin problems: \_\_\_\_\_

Chronic health problems (including seizures): \_\_\_\_\_

Current medication schedule:

### Immunization and dates

DPT	_____	_____	_____	_____	_____
Polio	_____	_____	_____	_____	_____
MMR	_____	_____	_____	_____	_____
HIB	_____	_____	_____	_____	_____
HEP B	_____	_____	_____	_____	_____
Other	_____	_____	_____	_____	_____

If child has not recieved all the immunizations as required please indicate the medical reasons why these were deleted: \_\_\_\_\_

Tb skin test and x-ray            negative \_\_\_\_\_ positive \_\_\_\_\_

Examination:

Height: \_\_\_\_\_ inches                      weight: \_\_\_\_\_ pounds

Blood pressure: \_\_\_\_\_

Urinalysis and blood work: \_\_\_\_\_

General appearance: \_\_\_\_\_

General condition of skin: \_\_\_\_\_

Head: \_\_\_\_\_

Eyes: \_\_\_\_\_ visual acuity: left \_\_\_\_\_ right \_\_\_\_\_

Ears: \_\_\_\_\_ hearing acuity: left \_\_\_\_\_ right \_\_\_\_\_

Nose: \_\_\_\_\_

Throat: \_\_\_\_\_

Mouth: \_\_\_\_\_

Neck: \_\_\_\_\_

Chest: \_\_\_\_\_

Heart: \_\_\_\_\_

Lungs: \_\_\_\_\_

Abdomen: \_\_\_\_\_

Genitalia: \_\_\_\_\_

Rectum: \_\_\_\_\_

Extremities: \_\_\_\_\_

Back: \_\_\_\_\_

Sickle cell: \_\_\_\_\_

General appearance: \_\_\_\_\_

Neurological: \_\_\_\_\_

Indicate any atypical behavior patterns and emotional responses if evident: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Recommendations concerning restriction of activity:

Full participation in activities: \_\_\_\_\_

Restricted participation in activities: \_\_\_\_\_

List restrictions and explain: \_\_\_\_\_

---

---

---

Diagnosis: \_\_\_\_\_

---

---

---

---

\_\_\_\_\_  
Signature of physician

\_\_\_\_\_  
date

\_\_\_\_\_  
Address

\_\_\_\_\_  
phone number

---

---

---