## Allen County Preschool Physical/Medical Diagnostic Evaluation Form

Child's Name	Date of Birth		
General Findings: Physical			
Childhood Diseases		_ Chronic Illness/Hospitalization_	
Allergies/Specific Precautions and/	or Treatments		
Current Medications/ Modified Diet	t		
Can the child fully participate in sch	nool activities? Yes	No	
Height		Nose	Back —
Weight			
BP			- Genitalia —————
Lymphatic	Ears	Chest	Extremities
		☐ Specific Concerns ☐ Specific Concerns	
<u>Hemoglobin Screening Results:</u> _Reason not completed: (Circle one)		Lead Screening Results:	Date
Physician Decision Religious Co		Coverage Other:	
Communication/Speech noted cor	icerns:		
<del>-</del>		Muscle Tone Cra	
	~ .		
	Gait	Station Ref	flexes
Gross Motor Skills: ☐ Within N	Normal Limits   Sr	pecific Concerns	
Gross Witten Skins: Within N	tormar Limits 🗀 Sp	becine Concerns	
<b>Fine Motor Skills:</b> Within N	Jormal Limits ☐ Sp	pecific Concerns	
<u>Diagnosis:</u> If the child has been splace and the date of the diagnosis		rith any of the following, please no	te where the evaluation took
place and the date of the diagnosis	<b>).</b>		
☐ Attention Disorders	(Specify)	(Place of Evaluation)	(date)
□ Autism Spectrum		(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)
	(Specify)	(Place of Evaluation)	(date)
□ Orthopedic Impairments	(Specify)	(Place of Evaluation)	(date)
□ Syndromes	(Specify)	(Place of Evaluation)	(date)
	ived immunizations requ	ime of this examination, the child is aired under Section 3313.671 of the	
Physician's Signature:		Date of Exam:	
As required by Rules 5101:2-12-37	and 5101-2-13-37, the c	child must be examined within twelv	e months prior to admission.
Physician's Name		Phone Number	

City, State, Zip Code:

Address: