Student Name: _____

Medical Evaluation

Medical evaluations will be requested for all new students and students who are due for their 3 year re-evaluation (ETR).

☐ We do not need a Medical evaluation this year.

☐ We need a copy of immunization records.

_____

☐ Our records indicate that your child is due for a medical evaluation. Our policy requires that a medical evaluation be completed every three years. If your child has a doctor's appointment in the near future you may ask them to complete the evaluation.

☐ All incoming 7th grade students are required to have 1 dose of Tdap or TD vaccine and 1 dose of MCV4 meningococcal vaccine for Meningitis.

☐ All incoming 12th grade students are required to have 2 doses of MCV4 meningococcal vaccine for Meningitis.

Vaccine waivers are available from nursing at 732-7017.

We will accept immunization records printed on your health care provider's forms.

Medical evaluations can be:

Mailed to: Wildey School, 2040 U.S. Hwy 50, Batavia, OH 45103

Faxed to: 513-732-4950

Emailed to: dbeebe@clermontdd.org

Please return to:
Clermont County Board of DD
Thomas A. Wildey School
2040 US Highway 50
Batavia, OH 45103
Phone: (513) 732-7015
Fax: (513) 732-4950
Email: dbeebe@clermontdd.org

Thomas A. Wildey School
Medical Evaluation Form

Date of Examination: _____ Sex: ☐ Male ☐ Female

Patient's Name: _____ Date of Birth: _____

PATIENT HISTORY

Diagnosis: _____

Past Injuries, Surgeries, Hospitalizations, Recurring Medical Problems: _____

_____

_____

Allergies and Skin

Problems:_____

Seizures (Type and Frequency): _____

Current medication schedule: _____

TB Skin Test and X-Ray: ☐ Negative ☐ Positive Date: _____ Type: _____

IMMUNIZATION AND DATES

Physician may attach copy of the immunization records.

DTP/Td					
POLIO					
MMR					
HIB					
HEP B					
VARICELLA					
Tdap					
MCV4					

If the child has not received all the immunizations as required, please indicate the medical reasons why these were deleted: _____

PHYSICAL EXAMINATION

Height: _____ inches Weight: _____ pounds

BP: _____ Temp: _____ Pulse: _____ Respirations: _____

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: _____

Back: _____

Extremities: _____

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: _____

_____

The herein mentioned child is declared to possess the following listed food allergies and/or special dietary needs. Alternate food(s) should be offered at school in accordance with federal, state and district policies.

Food Allergies: _____

_____ _____

Signature of Physician Date

_____ _____

Address Phone Number