BUTLER COUNTY EDUCATIONAL SERVICE CENTER
400 North Erie Blvd., Suite A Hamilton, OH 45011
EARLY CHILDHOOD PROGRAMS
Phone: (513) 887-3716 Fax: (513) 964-9655

PHYSICAL FORM

Child's Name _____ Sex: ☐ M ☐ F DOB: _____

Parent/Guardian Name _____ Home Phone _____

Address _____ Work Phone _____

_____ Zip _____

Center _____

BLOOD PRESSURE (3 yrs & >) _____ Height _____Weight _____ Head Circumference _____

Medical/Food Allergies: _____

HEARING							
DATE MO/DA/YR	AUDIOMETRY RESULTS (Pass/Fail)		OTHER TESTS (Specify)		NORMAL	UNDER CARE	DATE REFERRED
	R	L	R	L			

VISION							
DATE MO/DA/YR	DISTANCE ACUITY		STEREOPSIS		NORMAL	UNDER CARE	DATE REFERRED
	R	L	P	F			

Assessment:

_____ General Appearance _____ Eyes _____ Lungs _____ Skeletal System

_____ Skin _____ Ears _____ Abdomen _____ Neuro Muscular

_____ Lymph Nodes _____ Nose/Throat _____ Genitalia _____Heart

_____Oral Screening

Medications: _____

Describe any concerns or limitations:

_____

_____

Based upon the medical history and physical condition at the time of this examination, he/she is free from communicable disease and has received immunizations required by statute for admission to school under Section 3313.671 of the Ohio Revised Code, or has had the immunizations required by the State Department of Health for infant and toddlers. In addition, the child is in suitable condition for enrollment in a day care center.

Physician's Signature _____ **Date of Examination:** _____

Business Address _____ **Business Phone** _____

*****PLEASE ATTACH IMMUNIZATIONS*****