ALLEN COUNTY BOARD OF DD
MARIMOR SCHOOL MEDICAL INFORMATION FORM

Name _____ DOB _____ Age _____ Sex _____

Address _____ Phone _____
Street City ZIP

Parents/Legal Guardian _____

Date of Last Exam _____

TO BE COMPLETED BY PHYSICIAN

****

Weight _____
Height _____
General Appearance_____
_____
Skin_____
_____
Posture_____
EENT_____
_____
Heart_____
_____
Chest_____
Abdomen_____
_____
Extremities_____
_____
Genitalia_____
_____
Neurological_____
_____
Blood Pressure_____
Temperature_____

Note any visual condition that may affect educational performance.

_____
_____
_____

Note any hearing or ear condition that may affect educational performance.

_____
_____

Note any orthopedic, neurological, etc. condition that may limit participation in physical education or other school activities.

_____
_____

Required for students with Down Syndrome (age 5 and up): X-Ray for Atlantoaxial Instability
X-Ray Date _____
Positive _____
Negative _____

Required for children enrolled in the Allen County Board of DD Program.						**Reason Not Completed** (Check which applies)	
Assessments/ Screenings	Results		Completed Please circle one		Date Completed	Health Professional Decisions	Examples: religious conviction, insurance
Vision	Right (OD) 20/___	Left (OD) 20/ ___	YES	NO			
Hearing	Right	Left	YES	NO			
Dental			YES	NO			
Lead			YES	NO			
Hemoglobin			YES	NO			

CURRENT MEDICATIONS:

Name	Dose	Time	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Seizures/Epilepsy Yes_____ No_____
First Diagnosed_____ Type of Epilepsy_____
Last Seizure_____
Frequency of Seizures_____

Medical History of child (note any relevant surgeries, illnesses, injuries, chronic health conditions or diseases):
_____
_____
_____

Note any predisposing factors to the present condition and include your opinion as to etiology (i.e. familial, congenital, pre-natal, birth, genetic, environmental, etc.):
_____
_____
_____

Note any atypical behavioral patterns and emotional responses if evident:
_____
_____
_____

List any allergies: i.e., environmental and/or medication. Describe any special treatment needed for allergies.
_____
_____
_____

Note any condition that could result in a classroom emergency: i.e., diabetes, cardiac, asthma, or allergic reaction.
_____
_____
_____

Lifting Restriction (For age 16 and older):
YES _____ NO _____
How many pounds? _____

****

Immunizations--include dates given

DPT	_____	_____	_____	_____	_____
Tdap	_____				
Polio	_____	_____	_____	_____	
MMR	_____	_____			
Hib	_____	_____	_____	_____	
HepB	_____	_____	_____	_____	
HepA	_____	_____	_____	_____	
PNU	_____	_____	_____	_____	
VAR	_____	_____			
TB Type	_____	Results_____	Date_____		
Other	_____	_____	_____	_____	

****

Recommendations concerning Restriction of Activity/Participation in Program

Full participation in activities YES_____ NO_____
Restricted participation in activities YES_____ NO_____
If restricted participation, please explain:

_____

_____

Does this child have any communicable diseases? YES_____ NO_____
If, YES, please explain:_____

_____

_____

ALLEN COUNTY BOARD OF DD
VERIFICATION OF DEVELOPMENTAL DISABILITY

To be completed by the physician:

1. Briefly state the nature of the disability:

_____
_____
_____
_____

2. The disability or condition occurred during the developmental period (CA 0-22 years)

YES_____ NO_____

3. The disability or condition is expected to be long-term and/or permanent.

YES_____ NO_____

_____ _____
Physician's Signature Date

_____
Physician's printed name or office stamp

Address:

_____
_____

Telephone Number: _____

Return this form to:
Julia Vorst, School Nurse
Allen County Board of DD
Marimor School
2550 Ada Road
Lima, OH 45801-3340
419-221-1262
FAX 419-225-5184

3/11, 4/11