CINCINNATI HEBREW DAY SCHOOL - SAMUEL AND RACHEL BOYMEL CAMPUS
2222 LOSANTIVILLE ROAD
CINCINNATI, OH 45237
(513) 351-7777 (513) 351-7794

Student's Name: _____ **PHYSICIAN'S REPORT** Date of Birth: _____ Ver. 3/23

IMMUNIZATIONS

	Date	Date	Date	Date	Date
Chicken Pox					
DPT					
Td					
Polio Sabin (Tri)					
Measles					
Rubella					
Mumps					
HIB All dates must be recorded					
Hepatitis B					

SCREENING TESTS

VISION	Date	Right	Left
Muscle Balance			
Farsightedness			
Color			
Distance Acuity			
Wears Glasses	yes	no	
HEARING			

TUBERCULIN	Date	Test	Result

POSTURE (SCOLIOSIS)	Date	Test	Results

HEIGHT: **WEIGHT:**

Current Medications:

PHYSICAL ASSESSMENT CHECK ONE:

☐ Entirely within normal limits

☐ Abnormalities as follows:

History of any chronic illness:

History of hospitalizations: Date: _____ Date: _____

Any restricted activities:

ALLERGIES

Does the child have allergies: Yes ___ No

If so please specify:

Signature of examining physician:

Phone:

Comments:

Date: