JCBDD

JACKSON COUNTY BOARD OF DEVELOPMENTAL DISABILITIES

NICK ELLIOTT
SUPERINTENDENT

822 SELLERS DRIVE
PO BOX 607
JACKSON, OHIO 45640
740-286-6491

Medical Evaluations

STUDENT'S NAME: __________________________ DOB: _____________ GENDER: ____________ DATE: _________
ADDRESS: ____ PHONE: _____________

OBJECTIVE DATA:
HEIGHT ___________ WEIGHT ___________ BP ___________ P ___________ R ___________ TEMP____________

SCREENING TESTS: DATE DONE: _______________

VISION

DISTANCE ACUITY: R _____ L _____
MUSCLE BALANCE: PASS ___ FAIL ___ NOT DONE ___
FARSIGHTEDNESS: PASS ___ FAIL ___ NOT DONE ___
COLOR: PASS ___ FAIL ___ NOT DONE ___
CHILD WEARS GLASSES? YES ___ NO ___
TESTED WITH GLASSES? YES ___ NO ___
REFERRALS MADE? YES ___ NO ___

HEARING

AUDIOMETRIC THRESHOLDS:
R EAR: PASS ___ FAIL ___ NOT DONE ___
L EAR: PASS ___ FAIL ___ NOT DONE ___
OTHER TESTS (SPECIFY): ________________
____
CHILD WEARS HEARING AIDS? Y ___ N ___
TESTED WITH HEARING AID? Y ___ N ___
REFERRALS MADE? Y ___ N ___

SPEECH/LANDUAGE:
SPEECH ASSESSMENT: DONE ___ NOT DONE ___
CHILD HAS NO DISCERNIBLE SPEECH PROBLEM ___
CHILD HAS POSSIBLE PROBLEM WITH:
DISORDERS: (CHECK) ARTICULATION ___ RHYTHM ___ VOICE ___ LANGUAGE ___
SPEECH EVALUATION RECOMMENDED: YES ___ NO ___

LABORATORY TESTS:
HEMATOCRIT/HEMOGLOBIN ___ URINE PROTEIN ___ URINE BLOOD ___ URINE GLUCOSE ___
OTHERS: ____

PHYSICAL EXAMINATION: DATE EXAMINED __________ ESSENTIALLY NORMAL ____________
ABNORMALITIES AS FOLLOWS: ____

JCBDD DOES NOT DISCRIMINATE IN PROVISION OF SERVICES OR EMPLOYMENT BECAUSE OF HANDICAP, RACE, COLOR CREED, NATIONAL ORIGIN, SEX OR AGE. "AN EQUAL OPPORTUNITY EMPLOYER AND SERVICE PROVIDER."

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MEDICAL EVALUATIONS CONTINUED

IMMUNIZATIONS: (DATES AND/OR RESULTS)

DPT: ___________ ___________ ___________ ___________ ___________
POLIO: ___________ ___________ ___________ ___________ ___________
MMR: ___________ ___________ ___________ ___________ ___________
HIB: ___________ ___________ ___________ ___________ ___________
PPD: ___________ ___________ ___________ ___________ ___________
OTHER: ___________ ___________ ___________ ___________ ___________

IS THIS CHILD ABLE TO PARTICIPATE FULLY IN THE FOLLOWING?

A. CLASSROOM AND ACADEMIC ACTIVITIES? YES ___ NO ___
B. PHYSICAL EDUCATION CLASSES? YES ___ NO ___
C. COMPETITIVE ATHLETICS? YES ___ NO ___

IF LIMITATIONS ARE ADVISED, PLEASE SPECIFY: ____
____

SEIZURE HISTORY? TYPE AND TREATMENT: ____
ALLERGIES KNOWN? ____

IF THIS CHILD HAS ANY PHYSICAL, DEVELOPMENTAL, OR BEHAVIOR PROBLEMS, HOW CAN THE SCHOOL ASSIST WITH SPECIAL PROGRAMS, PLACEMENT, OR ATTENTION? ____
____
____

PHYSICIAN'S ASSESMENT:

PROBLEMS: RECOMMENDED SCHOOL MANAGEMENT:

1. ____
2. ____
3. ____

MEDICATIONS (DOSE, ROUTE, DURATION, PURPOSE, ETC) :
____
____

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MEDICAL EVALUATIONS CONTINUED

SUMMARY OF MEDICAL DATA THAT IS RELEVANT TO A DIAGNOSIS OF DEVELOPMENTAL DISABILITIES IN THE PATIENT:____
____
____

PHYSICIAN'S NAME ____________________________________
ADDRESS ____________________________________
____
PHONE ____________________________________

PLEASE PRINT OR STAMP

PHYSICIAN'S SIGNATURE ______________________________________
DATE ___________________