Medical Statement

(To Be Completed by Physician)

Please Return to: **Administrative Assistant SSA**
Riverside Developmental Disabilities
1625 Troy Sidney Road
Troy, OH 45373

Name of Patient ______________________________

DOB ________________

Developmental Disability / Medical Diagnosis ______________________________

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Date of Onset of Condition(s) Leading to Developmental Disability → ________________

Medical History
- ☐ Chicken Pox
- ☐ Heart Disease
- ☐ Chronic Otitis
- ☐ Diabetes
- ☐ Meningitis
- ☐ Measles
- ☐ German Measles
- ☐ Tuberculosis
- ☐ Scoliosis
- ☐ Atlantoaxial Dislocation
- ☐ Other________________

Date of Last Tetanus ________________

Allergies ______________________________

Surgeries/Hospitalizations ______________________________

Seizures/Epilepsy Type/Frequency ______________________________

TB Skin Test Date ___________ (Required only if considered to be at high risk by the physician)

☐ Negative ☐ Positive

Chest X-Ray Date ___________ (Required Only if a Positive TB Skin Test)

☐ Negative ☐ Positive

CURRENT MEDICATION SCHEDULE

Type	Dosage	Time	Beginning Date	Ending Date

IMMUNIZATIONS	Date	Date	Date	Date	Date
DTP					
Polio					
MMR					
HIB					
Hep B					
Other					

Physical Assessment

		Findings
General Appearance	☐ Normal ☐ Abnormal	________________
Head	☐ Normal ☐ Abnormal	________________
Skin	☐ Normal ☐ Abnormal	________________
Lymph Nodes	☐ Normal ☐ Abnormal	________________
Eyes	☐ Normal ☐ Abnormal	________________
Ears	☐ Normal ☐ Abnormal	________________
Nose/Throat	☐ Normal ☐ Abnormal	________________
Teeth, Gums, Tongue, and Palate	☐ Normal ☐ Abnormal	________________
Lungs	☐ Normal ☐ Abnormal	________________
Abdomen	☐ Normal ☐ Abnormal	________________
Genitalia	☐ Normal ☐ Abnormal	________________
Skeletal System	☐ Normal ☐ Abnormal	________________
Neuro Muscular	☐ Normal ☐ Abnormal	________________
Mental Health History	☐ Normal ☐ Abnormal	________________

State Mandated Screening for Pre-School

Hematocrit Level_________**Date**_________

State Mandated Screening for Under Age 6

Lead____________________**Date**_________

Screening Results (if applicable)
(Date - Results - Follow-Up)

Vision ________________________________
Hearing ________________________________
Speech ________________________________
Mammogram ________________________________
Pap Smear ________________________________
Prostate ________________________________
Urinalysis ________________________________
Colonoscopy ________________________________
Fecal Occult Blood Test ______________________
Bone Density ______________________________

Height ___________ Weight ____________ BP ________________ Pulse ________________

Adaptive Equipment ☐ Glasses ☐ Hearing Aid ☐ Trach ☐ G/J Tube ☐ Oxygen ☐ Cane ☐ Prosthesis ☐ Wheelchair
☐ Communication Device ☐ Orthotics ☐ Other___________________________________

Dietary Restrictions ____

Physical Restrictions (if applicable) Lifting ☐ < 10# ☐ < 15# ☐ < 40# ☐ < Specify ______________________

Standing________________________Walking___________________________Sitting______________________________

Recommendations____
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This is to certify that I have examined the aforesaid patient and have found that he/she has had the immunizations in compliance with Section 3313.671 of the Ohio Revised Code for admission to school, or has had the immunizations required by the Ohio Department of Health for infants and toddlers, or the Miami County Board of MR/DD Policy for admission to adult programs, or is to be exempted from these requirements for medical or religious reasons. I have also found that he/she is free from apparent communicable disease and is in suitable condition to participate in any Riverside program, based on his/her medical history and physical condition at the time of this examination.

Physician's Signature ____Date of Medical Evaluation______________

Physician's Name (Please Print)____

Address ____Phone__________________

Physician's Emergency Phone____