

Centerville Preschool

Health Examination Record

Primary Village North / Primary Village South

Child's Name	Date of Birth
Home Address	
Phone Number	
Father's Name	Business Phone
Mother's Name	Business Phone

This is to certify all of the following:

- * I have examined this child and found that he or she is in suitable condition for participation in Preschool.
 - * The child has had the age appropriate immunizations recommended by the Ohio Department of Health.
- List an limitation or health conditions for this child (including an allergies, daily medication and or dietary restrictions)
- _____

Recommended Immunization (enter month, day and year)					
Vaccines	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5
Diphtheria, Tetanus, Pertussis (DTaP)					
Hepatitis (Hep B)					
Haemophilus Influeza type b (HIB)					
Measles, Mumps, Rubella (MMR)					
Polio					
Varicella (chicken pox)					
Influenza					
Pneumococcal Conjugate (PCV)					
Hepatitis A					
	Date	Test / Results	Vision	Date	Results
Tuberculin			Distance Acuity	Right-	Left -
Lead			Muscle Balance	Right-	Left -
Hematocrit			Hearing	Date	Results
Height		%	Puretone	Right-	Left -
Weight		%	Tympanometry	Right-	Left -
Comments:					
Is there any reason why the student can not carry out a full program of school work? YES /NO reason? _____					
Signature of Examining Physician /Physican's Assistant /Advanced Practice Nurse			Date of most recent Examination		
Name of Examining Physician /Physican's Assistant /Advanced Practice Nurse			Office Phone Number		
Address					

Please complete the back side of this form.

CHILD'S HEALTH HISTORY:

Allergies: Please list and describe allergies or reactions to:

Medicines/drugs:

Food/plants/animals/insects/other

Recommended treatment if allergy is severe
--

Injuries and Illness Please list any severe injury, illness, or other health condition your child has had:

Injury/Illness	Date or Age of Child	If hospitalized, where, when?

<u>Additional Information:</u>

What medications are given daily? (include dosage and time given)

What medications are given frequently but not daily?
--

Do you have other comments or concerns about your child's health or development that you would like the school to be aware of? If yes, explain briefly:

Is there anything about your child that the teacher needs to know to understand him/her better?

Parent/Guardian Signature	Date
---------------------------	------