Olentangy Preschool

ANNUAL MEDICAL DIAGNOSTIC SCREENING FORM

THIS FORM MUST BE COMPLETED, SIGNED AND DATED BY A PHYSICIAN

FORM MUST BE PROVIDED WITHIN 30 BUSINESS DAYS OF ENTRANCE INTO THE PRESCHOOL PROGRAM AND ANNUALLY THEREAFTER

Child's Name: _____ Date of Birth: _____

Assessments/Screenings	Assessment/Screening Completed (circle one)		Date Completed	Reason Not Completed (health professionals decision, insurance coverage, religious conviction, other)
Vision	Yes	No		
Hearing	Yes	No		
Lead*	Yes	No		
Hemoglobin**	Yes	No		
Height				
Weight				

*ZIP CODE 43015 MUST HAVE ONE DOCUMENTED TEST IF AGE 3-6 **PHYSICIAN DETERMINED

Please list any limitations or health conditions (including allergies, medications, dietary restrictions, etc):

_____

_____

This Child is free from apparent communicable disease and is in suitable condition to attend a preschool program based on his/her medical history and physical condition at the time of this examination.

_____ _____

Signature of examining Health Professional **Date of Exam**

Circle one: Physician Physician's Assistant Advanced Practice Nurse

Office Address:_____ Office Phone:_____

Return to your preschool building nurse
OR fax to 740-657-4696

Updated 3/29/2017