Oakwood City Schools Preschool Program

Please return this form to the preschool
1701 Shafor Blvd. Dayton, OH 45419

Name_____ **DOB:**_____ **Sex:**_____**M** _____**F**

Height:_____(____%) **Weight**_____(____%) **BP**_____ **Pulse**_____**Respiration**_____

Heart_____ **Head**_____ **Eyes**_____ **Ears**_____ **Nose**_____

Teeth_____ **Neck**_____**Chest**_____ **Lymphatics**_____ **Back**_____

Abdomen_____**Genitalia** _____ **Extremities**_____**Neurological**_____

Orthopedics_____**Oral Motor/Eating/Feeding**_____

☐ **No significant findings were noted during general physical exam.**
☐ **Significant findings were noted during general physical exam. Please specify:**_____

ALLERGIES:_____

Medications: **Child takes prescribed medication on regular basis?** ☐ **No** ☐**Yes**

Medication	Dosage	Prescribed for:
1.		
2.		
3.		

Required By Ohio Revised Code

Blood Lead screening Date:_____ **Results:**_____ **Hematocrit test Date:**_____**Results:**_____**%**

Vision Screening Date: _____
☐**Within Normal Limits Yes/No (If not, specify:** _____**)**
☐ **Wears Corrective Lenses Yes/No**
☐ **Eye Surgery Yes/No (Specify:**_____**)**

Hearing Screening Date: _____
☐**Within Normal Limits Yes/No (If not, specify:** _____**)**
History of Frequent Ear Infections Yes/No
PE Tubes Inserted Yes/No (Date:_____**)**

Diagnosed Disorders/Syndromes:

☐**List Developmental Disorders/Syndromes/Medical Concerns:**_____

Accommodations needed due to Physical Limitations_____

Other Special Instructions_____

Behavioral Concerns:
❑ **Hyperactivity** ❑ ☐**Distracted** ❑**Short Attention Span**☐ ❑ **Withdrawn** ❑**Aggression** ❑**Anxiety** ❑**Other**_____

Immunizations		Ohio Law Requires		Dates of Immunizations Must include month/day/year	
DTaP, DTP or DT (Pediatric)	4 Doses				
Polio Vaccine	3 Doses				
HIB*	3 or 4 Doses				
Hepatitis B**	3 Doses				
Varicella	1 Dose				
MMR	1 Dose				
If Separate					
Rubella	1 Dose				
Rubeola	1 Dose				
Mumps	1 Dose				
Other Vaccines					

❑ **I certify that no communicable disease is evident at the time of this examination and the child may attend a preschool program.**

Physician Office Stamp

Physician's Signature (MD,DO, or NP)

Date_____