

Anthony Wayne and Care-A-Lot Early Childhood Center School Year 2017-2018 Enrollment

**Child's Medical Statement
PHYSICAL FORM**

This form may be completed by the following professionals: a physician, physician's assistant, clinical nurse specialist, or certified nurse. It is required annually. It may be completed on an annual schedule according to the initial examination date OR it may be completed on a schedule as required by the program for annual updates.

This is to certify that I have examined (Child's Name: _____) on (Date: _____) and have found he/she:

1. _____ Has had the immunizations required by 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, toddlers, and preschool children. (Please attach a copy of the immunization record). Immunization **Record must contain: Month/day/year of each immunization (This information is required by the first day of attendance.)** **OR**

_____ Is to be exempted from these requirements for medical, religious or philosophical reasons. **Please request a "Medical, Religious or Philosophical Exemption Form" to attach to the Immunization Record.**

Physicians please note your instructions regarding this child receiving the 5th Dtap and the 4th Polio Vaccine:
 _____ Prior to Preschool Entry or _____ Prior to Kindergarten Entry

2. **Physical Assessment** Did the examination reveal any abnormalities in the following areas?

General Appearance	Yes	No	Skin	Yes	No
Lymph Nodes	Yes	No	Eyes	Yes	No
Ears	Yes	No	Nose/Throat	Yes	No
Teeth/gums/tongue/palate	Yes	No	Heart/blood pressure	Yes	No
Lungs	Yes	No	Abdomen	Yes	No
Skeletal system	Yes	No	Muscular System	Yes	No
Allergies/Treatment	Yes	No	Any Medical Diagnosis	Yes	No

Please explain any "Yes" answer from above _____

Required Screenings (Ohio Department of Education) Please enter CURRENT LEVELS

Hemoglobin Level _____ Date _____	Lead Level _____ Date _____	Height	Weight
Visual Acuity Right Eye _____	Visual Acuity Left Eye _____	Hearing Right Ear Pass____ Fail____	Hearing Left Ear Pass____ Fail____

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

Physician's Printed Name: _____	Date: _____
Physician's Signature: _____	
Physician's Address: _____	