PERRY LOCAL PRESCHOOL

Child's Medical Statement

This is to certify that I have examined (Child's name) _____

on (date of exam) _____ **and have found that 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 and toddlers, or

   _____ is to be exempted from these requirements for medical or religious reasons.

   Immunization Record: Enter month/day/year of each immunization.

DPT	1	2	3	4	5*
Polio	1	2	3	4*	
MMR**	1				
HIB	1				
HBV	1	2	3		
Varicella	1				

* The 5th DPT and 4th polio should be administered just prior to kindergarten entrance.
** If measles, mumps, rubella not given as MMR, give dates for each immunization:

Measles _____ Mumps _____ Rubella _____

2. 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.

3. **Allergies:** (List all allergies affecting the child and any special precautions or treatments indicated for these allergies) _____

_____

_____

4. **Medications:** (List all medications currently being administered to the child.) _____

_____

_____

5. **Dietary Restrictions:** (List all modified dietary restrictions affecting the child.) _____

_____

_____

6. **Handicapping conditions or chronic physical problems:** (List handicapping conditions or all chronic physical problems affecting the child.) _____

_____

_____

7. **History of hospitalizations:** (List dates of all hospitalizations of the child.) _____

_____

_____

8. **Diseases:** (List all diseases the child has had.) _____

_____

_____

9. Indicate any limitations or modifications of the child's participation in daily school activities or any special treatments. _____

_____

_____

_____

10. Height _____ Weight _____

11.

Required Tests	Date	Results
Lead		
Hematocrit		

Name of Physician (please print): _____

Address: _____

City, State, and Zip Code: _____

Phone: _____

Physician's signature: _____ **Date of signature:** _____

Parent's signature: _____ **Date:** _____

***This form must be completed within 60 days of enrollment in the Perry Local Preschool.
Medical evaluation due by: _____