This medical statement MUST be filled out and signed by a licensed physician and returned to preschool before your child can start

WESTERVILLE CITY SCHOOLS
PRESCHOOL PROGRAM
FAX: 614-797-7451

ELC PRESCHOOL NURSE
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OHIO DEPARTMENT OF EDUCATION DIVISION OF EARLY CHILDHOOD EDUCATION CHILD'S MEDICAL STATEMENT

THIS IS TO CERTIFY THAT I HAVE EXAMINED:
CHILD'S NAME:
CHILD'S DOB:
DATE OF EXAM:

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 THE REQUIREMENTS FOR MEDICAL OR RELIGIOUS REASONS.
2. **ATTACH IMMUNIZATION RECORD** OR ENTER MONTH/DAY/YEAR OF EACH IMMUNIZATION. (THIS INFORMATION IS REQUIRED PRIOR TO THE FIRST DAY OF ATTENDANCE).

DTP	1.	2.	3.	4.	5.*	5TH Dose Required Prior to Kindergarten
POLIO (IPV)	1.	2.	3.	4.*		4th Dose Required Prior to Kindergarten
MMR*	1.	2.	Measles	Mumps	Rubella	2nd Dose Required Prior to Kindergarten
HEPATITIS B	1.	2.	3.			Last Dose needs to be after 24 weeks old
VARICELLA (CHICKENPOX)	1.	2.				1st Dose on or after 1st Birthday
HIB	1.	2.	3.	4.		0-14 MO: 3-4 Doses 15-59 MO: 1 Dose
HEPATITIS A	1.	2.				1st Dose after 12 months old
INFLUENZA	1.					
(PNEUMOCOCCAL)						
ROTOVIRUS						

*If Measles, Mumps, Rubella not given as MMR, give dates for each immunization

***REQUIRED SCREENINGS:** PLEASE INDICATE THE RESULTS OF ANY SCREENINGS

SCREENING	DATE	RESULTS	RESULTS NOT COMPLETED	FOLLOW-UP REQUIRED? WHEN
Vision (@2yrs. Beg at age 3)				
Hearing (@2yrs. Beg at age 3)				
Speech				
Height				
Weight				
Lead Screening			Not at risk Not indicated	
Hematocrit or Hemoglobin			Not at risk Not indicated	

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According to Rule 3301-37-05A, the medical statement is required no later than 30 days after admission. For 3 year olds, examination should be within 6 months prior to admission. For 4 year olds – within 12 months prior to admission.

Medical History		
Allergies ***(food, environmental and other*)**	Symptoms:	Treatment:
Diet Restrictions::		
Current Medications (dosage and frequency):		
Known Health Conditions: (if seizures , describe type and frequency), sickle cell, etc.: List precautions or limitations required for school		

3. 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 (THIS INFORMATION IS REQUIRED PRIOR TO THE FIRST DAY OF ATTENDANCE).

Physician's Signature or Stamp	Date Completed:
Physician's Name (Print)	
Physician's Address City, State, Zip Code	
Physician Phone	
Parent(s)/Guardian Name	
Child's Birthdate	

A MEDICAL STATEMENT 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. IT MUST BE CURRENT FOR THE CHILD'S ENDROLLMENT YEAR.

REV 2/22