SCHOOL ENTRANCE MEDICAL RECORD – PRESCHOOL
TAKE THIS FORM TO YOUR PHYSICIAN TO COMPLETE

Office Use

PreSchool
Center Based___
Itinerant ___

STUDENT NAME________________________ DATE OF BIRTH______________ GENDER M / F

IMMUNIZATION HISTORY MONTH, DAY AND YEAR ARE REQUIRED FOR EACH OF THE FOLLOWING DATES:					
DPT Vaccine	Polio Vaccine		Hepatitis B Vaccine	Varicella Vaccine/Chicken Pox	HIB
1	OPV	IPV	1	1	1
2	1	1	2	2	2
3	2	2	3		3
4	3	3	4		4
5	4	4	4th required only if 3rd does was administered under 6 months of age.		
MMR Vaccine (Measles (Rubeola), Mumps, Rubella)			Tuberculin Test (not required)		
1 (recd after 1st birthday)			Date:	Positive	
2 (at least 28 days after 1st dose)			Type:	Negative	

Lead Poisoning	☐ Date	________	Type	☐ C	☐ V	Results ________	µg/dL
Hemoglobin	☐ Date		Type	☐ C	☐ V	Results	µg/dL

PHYSICAL EXAMINATION

DATE OF EXAM: ______	Eyes: ______	Ears: ______
Height: ______	Vision: R: 20/ ______	Hearing: Type ______
Weight: ______	L: 20/ ______	R: ______ L: ______

Referred to ear or eye specialist? Yes __________ No ______

Nose: __________ Throat: __________

Mouth: __________ Teeth: __________

Is dental work indicated? Yes __________ No ______

If so, are plans being made? Yes __________ No ______

Posture: ______	Abdomen: ______	Nervous System: ______
Skin: ______	Genitalia: ______	Lungs: ______
Neck: ______	General Condition: ______	Hernia: ______
Heart: ______	Orthopedic: ______	Urinalysis: ______

Remarks & Recommendations: ____________________

Allergies (Food/Insect): __________ Recommended Treatment: __________

Physician Name (Please Print):________________ Physician Signature ________________

Office of Early Learning and School Readiness

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Child Medical Statement

Student's Name ____ Date of Birth________________________

Limitations or health condition (including allergies, medications, dietary restrictions)

Immunizations	Please circle one	
Complete for age	Yes	Yes
In Process	No	No

Exempt from Immunizations	Please circle one	
Religious conviction	Yes	Yes
Health concern	No	No
Other:		

This child has been examined and is in suitable condition to participate in group care.

Signature of examining Physician/Physicians Assistant or Advanced Practice Nurse (circle one) Address: Phone:	Date of Exam

Required for children enrolled in a Preschool Special Education Program				**Reason not completed (Check which applies)**	
Assessments/Screenings	Completed Please circle one		Date Completed	Health professional decision	Examples: religious conviction, insurance coverage, other
Vision	Yes	No			
Hearing	Yes	No			
Dental	Yes	No			
Lead	Yes	No			
Hemoglobin	Yes	No			

TAKE THIS FORM TO YOUR PHYSICIAN TO COMPLETE

SCHOOL ENTRANCE ORAL ASSESSMENT RECORD – PRESCHOOL
TAKE THIS FORM TO YOUR DENTAL CARE PROVIDER TO COMPLETE

Office Use
PreSchool
Center Based___
Itinerant ___

STUDENT NAME__________________________ DATE OF BIRTH _______________GENDER M / F

DATE OF EXAM __________________________

The following services have been performed – Check ALL that apply:

Examination	☐	Fluoride application	☐	Oral prophylaxis (cleaning)	☐	Prescription for fluoride supplement	☐	Other
Orthodontic Assessment	☐	Radiographs	☐	Dental Sealant	☐	Treatment (restoration, pulp therapy	☐	

The following oral hygiene instruction was provided – Check ALL that apply:

Tooth brushing	☐	Flossing	☐	Dietary counseling	☐	Use of fluoride mouth rinse	☐	Other

The following statements are applicable – Check ALL that apply:

☐	All necessary preventative services have been performed. (Fluoride treatment, prophylaxis)
☐	No restorative services are required at this time.
☐	Further treatment is indicated (See comments)
☐	Further appointments have been arranged. (Orthodontic, restorative)
☐	Routine recall visits recommended
	Comments

Dentist's Name (Please Print):______________________ Dentist's Signature ___________________________