PRESCHOOL COMMUNICABLE DISEASE

WORTHINGTON SCHOOLS

CHILD'S MEDICAL STATEMENT

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

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. __________

Hib: 1. __________ 2. __________ 3. __________ 4. __________

Pneumococcal Conjugate: 1. __________ 2. __________ 3. __________ 4. __________

Hepatitis B: 1. __________ 2. __________ 3. __________

Hepatitis A: 1. __________ 2. __________

Measles, mumps, rubella – usually combined as MMR: 1. __________ *2. __________

Varivax (varicella): 1. __________ *2. __________

Rotavirus: 1. __________ 2. __________ 3. __________

Influenza: 1. __________

*The 5th DPT, 4th Polio, 2nd MMR and 2nd Varivax are required to enter Kindergarten.

2) is free from 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.

____
Physician's Name (please print)

____
Parent's Name

____
Physician's Signature

____
Child's Date of Birth

____
Physician's Street Address

____
City, State, Zip Code

____
Physician's Phone Number

Return to:

Sutter Park School
1850 Sutter Parkway
Powell, OH 43065
614-450-4900
Fax: 614-883-3260