

**THIS FORM MUST BE COMPLETED WITHIN 30 DAYS OF ENROLLMENT
AND UPDATED ANNUALLY, 13 MONTHS FROM LAST PHYSICAL**

DUE:

**CHILD MEDICAL STATEMENT
SHEFFIELD-SHEFFIELD LAKE CITY SCHOOLS PRESCHOOL PROGRAM**

Child's Name		Date of Birth	
Immunizations:			
Complete for Age <input type="checkbox"/> yes <input type="checkbox"/> no		In Process <input type="checkbox"/> yes <input type="checkbox"/> no	
Exempt from Immunizations:			
<p>Exceptions to Immunization requirements pursuant to 5104.014 ORC (please include names of requirement diseases against which the child has not been immunized and whether it is because the immunization is medically contraindicated, not medically appropriate for the child's age, or declined by the parent)</p>			
<input type="checkbox"/> I have declined to have my child immunized against one or more of the diseases required by 5104.014 of the Ohio Revised Code. Please note diseases above. Sign below.			
Parent Signature		Date	
ATTACH A COPY OF THE CHILD'S IMMUNIZATION RECORD WITH DATES OF DOSES OF ALL IMMUNIZATIONS			
Limitations or health conditions, including allergies, medications, and dietary restrictions			
Recommended Assessments/Screenings (optional)			Measurements
Vision <input type="checkbox"/> yes <input type="checkbox"/> no	Dental <input type="checkbox"/> yes <input type="checkbox"/> no	Lead <input type="checkbox"/> yes <input type="checkbox"/> no	Height
Hearing <input type="checkbox"/> yes <input type="checkbox"/> no	Hemoglobin <input type="checkbox"/> yes <input type="checkbox"/> no	Other	Weight
			BMI
<p>This above named child has been examined, the immunization status recorded, and the child is in suitable condition for participation in group care. This above named child has been immunized in accordance with the requirements of section 5104.014 of the Ohio Revised Code. (exceptions noted above)</p>			
Signature of Examining Physician/Physician's Assistant/Advanced Practice Registered Nurse/Certified Nurse Practitioner			Date of Examination
Name of Examining Physician/Physician's Assistant/Advanced Practice Registered Nurse/Certified Nurse Practitioner			Telephone Number
Street Address			
City, State and Zip Code			