



**Centerville Preschool**  
 Primary Village North - 6450 Marshall Rd, Centerville, OH 45459  
 Primary Village South - 8388 Paragon Rd, Centerville, OH 45458

937.438.6030 ext. 4709     937.438.6076  
<https://preschool.centerville.k12.oh.us/>

Please return via fax or email to: [kathryn.collins@centerville.k12.oh.us](mailto:kathryn.collins@centerville.k12.oh.us)

**Health Examination Record**

Child's Name	Date of Birth
Home Address	
Phone Number	
Father's Name	Business Phone
Mother's Name	Business Phone

This is to certify all of the following:

- \* I have examined this child and found that he or she is in suitable condition for participation in Preschool.
- \* The child has had the age appropriate immunizations recommended by the Ohio Department of Health.

List any limitation or health conditions for this child (including an allergies, daily medication and or dietary restrictions)

Recommended Immunization (enter month, day and year)					
Vaccines	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5
Diphtheria, Tetanus, Pertussis (DTaP)					
Hepatitis (Hep B)					
Haemophilus Influeza type b (HIB)					
Measles, Mumps, Rubella (MMR)					
Polio					
Varicella (chicken pox)					
Influenza					
Pneumococcal Conjugate (PCV)					
Hepatitis A					
	<b>Date</b>	<b>Test / Results</b>	<b>Vision</b>	<b>Date</b>	<b>Results</b>
Tuberculin			Distance Acuity	Right-	Left -
Lead			Muscle Balance	Right-	Left -
Hematocrit			<b>Hearing</b>	<b>Date</b>	<b>Results</b>
<b>Height</b>		%	Puretone	Right-	Left -
<b>Weight</b>		%	Tympanometry	Right-	Left -

**Comments:**

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Is there any reason why the student can not carry out a full program of school work? YES /NO reason? \_\_\_\_\_

Signature of Examining Physician /Physican's Assistant /Advanced Practice Nurse	Date of most recent Examination
Name of Examining Physician /Physican's Assistant /Advanced Practice Nurse	Office Phone Number
Address	

**Parents, please complete the back of this form**

# CHILD'S HEALTH HISTORY:

Allergies: Please list and describe allergies or reactions to:

Medicines/drugs:
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Food/plants/animals/insects/other
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Recommended treatment if allergy is severe
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Injuries and Illness Please list any severe injury, illness, or other health condition your child has had:

Injury/Illness	Date or Age of Child	If hospitalized, where, when?

Additional Information:
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What medications are given daily? (include dosage and time given)
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What medications are given frequently but not daily?
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Do you have other comments or concerns about your child's health or development that you would like the school to be aware of? If yes, explain briefly:
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Is there anything about your child that the teacher needs to know to understand him/her better?
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Parent/Guardian Signature	Date
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