Otsego Preschool Child Medical Statement

ONLY THIS FORM WILL BE ACCEPTED

Child's Name _____ Date of Birth _____

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

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

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

Signature of examining Physicians/Physicians Assistant or Advanced Practice Nurse (circle one) Address: Phone:	**Date of exam** **Signature of examining physician**

	Required for ALL children enrolled in Otsego Preschool.			**Reason Not Completed (check which applies)**	
Assessment/Screenings	Completed please circle one		Date Completed	Health Professional decision	Examples:religious, conviction,Insurance coverage, other
Vision	Yes	No			
Hearing	Yes	No			
Lead	Yes	No			
Hemoglobin	Yes	No			

Height _____ Weight_____ **OVER**

PHYSICIAN REPORT AND IMMUNIZATIONS					
VACCINES	Requirements for Pre-School				
DPT Diphtheria, Tetanus, Pertussis	4 doses of DTaP, DTP, or DT. or any combination				
Polio	3 doses if a combination of OPV or IPV was administered				
MMR Measles, Mumps, Rubella	1 dose of MMR. Dose must be administered on or after the first birthday.				
Hib Haemophilus Influenza Type b	3 or 4 doses depending on the vaccine type and the age when the child began the 1st dose and the last dose is after 12 months or 1 dose is given on or after 15 months of age.				
Hep B Hepatitis B	3 doses of Hapatitis B				
Varicella Vaccine (eg. Var MMRV)	1 dose Varicella vaccine (minimum age: 12 months)				

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Otsego Local Schools
18505 Tontogany Creek Road, Suite 4
Bowling Green, Ohio 43402
419-823-4381, option 4

EXAM DATE: _____

PHYSICIAN'S SIGNATURE:

_____

Physician Name: _____

Physician Address: _____

_____

Physician Phone Number: _____

Child's Name: _____

LAST ***FIRST*** ***MIDDLE***

_____ _____

Father's Name **Mother's Name**

OVER