



Innovate Collaborate Inspire

Preschool Medical Statement

To be completed by a Physician, Physician Assistant, or Nurse Practitioner

Student Name: _____ Date of Birth: _____ Sex: Male Female
Parent/Guardian Name: _____ Address: _____
Phone: _____ City, State, Zip Code: _____

Medical Examination

The above named child has been examined and is in suitable condition for participation in preschool. Yes No

Date of Examination: _____

Please list any additional medical information that will assist in caring for the above named child (if separate document, please attach to form): _____

Immunizations

Section 5104.014 of the Ohio Revised Code requires immunizations against the following diseases:
Chickenpox, Diphtheria, Haemophilus influenzae type b, Hepatitis A, Hepatitis B, Influenza, Measles, Mumps, Pertussis, Pneumococcal disease, Poliomyelitis, Rotavirus, Rubella, and Tetanus

COMPLETED BY HEALTHCARE PROVIDER

The above named child has been immunized against the diseases listed above.* Yes No

If the immunizations are NOT completed, why? Medically Contraindicated Not medically appropriate for the age of child

COMPLETED BY PARENT/GUARDIAN ONLY IF WAIVING AN IMMUNIZATION(S)

I have declined to have my child immunized for reasons of conscience, including religious convictions against all of the disease listed above OR against the following diseases: _____

Parent/Guardian Signature: _____ Date: _____

***ATTACH A COPY OF THE CHILD'S IMMUNIZATION RECORD INCLUDING DATES (MM/DD/YYYY FORMAT) OF DOSES OF ALL IMMUNIZATIONS.**

Healthcare Provider Information

Healthcare Provider's Signature: _____ Date of Signature: _____

Provider Name (Please Print or Type) _____ Phone Number _____

Address _____

City, State, Zip Code _____

Health History

To be completed by a Parent or Guardian

Student Name: _____ Date of Birth: _____ Sex: Male Female
 Parent/Guardian Name: _____ Address: _____
 Phone: _____ City, State, Zip Code: _____

Medical History

Cause of Developmental Disability, if Known	
Chronic Medical Condition(s) (Diagnosis)	
Allergies, Reactions, and Treatment of allergy (Foods/Medications/Other)	
Seizures	
Surgeries/Hospitalizations	
Physical Restrictions	
Dietary Restrictions/Food Supplements/Modified Diet	
Any other important medical history	

Current List of Medications (Prescription and Non-Prescription)

Name of Medication	Dosage	Purpose	Administered at School***	
			<input type="checkbox"/> Yes	<input type="checkbox"/> No
			<input type="checkbox"/> Yes	<input type="checkbox"/> No
			<input type="checkbox"/> Yes	<input type="checkbox"/> No
			<input type="checkbox"/> Yes	<input type="checkbox"/> No

***If medication needs to be administered or kept at school, complete an "Administration of Medication Request Form" for school

Parent/Guardian Signature: _____

Date: _____

Mini Monarch Academy
 1280 Charles Lane
 Marysville, OH 43040

School Office: 937-578-6700
 Fax: 937-814-4122

