Ohio Valley ESC
Bright Beginnings Preschool

Child Medical Statement

Required for ALL children enrolled in Preschool, Special Education, and Early Childhood Education Grant Programs

Child's Full Name: _____ Date of Birth: _____/_____/_____

School:_____ Age: _____ Height _____ Weight: _____

Physician's Name: _____

I authorize my physician to release the completed medical statement to Bright Beginnings Preschool. (Fax: 740-376-5809)

Parent/Guardian Signature:_____ Date:_____

To be completed by Child's Physician

Allergies: _____ History: _____

☐ Normal	☐ Abnormal	General Appearance	☐ Normal	☐ Abnormal	Speech	
☐ Normal	☐ Abnormal	Posture, Gait	☐ Normal	☐ Abnormal	Teeth, Gums	
☐ Normal	☐ Abnormal	Nose, Mouth, Pharynx	☐ Normal	☐ Abnormal	Head	
☐ Normal	☐ Abnormal	Bones, Joints, Muscles	☐ Normal	☐ Abnormal	Heart	
☐ Normal	☐ Abnormal	Skin	☐ Normal	☐ Abnormal	Lungs	
☐ Normal	☐ Abnormal	Muscular Coordination	☐ Normal	☐ Abnormal	Extremities	
☐ Normal	☐ Abnormal	Eyes	☐ Normal	☐ Abnormal	Abdomen	
☐ Normal	☐ Abnormal	Symmetrical Light Reflex	☐ Normal	☐ Abnormal	Genitalia	
☐ Normal	☐ Abnormal	External Aspects	☐ Normal	☐ Abnormal	Development	
☐ Normal	☐ Abnormal	Ears	☐ Normal	☐ Abnormal	Social/Emotional	☐ Normal
☐ Abnormal	Glands (Lymphatic/Thyroid)	☐ Normal	☐ Abnormal	Neurological		

Assessments/Screenings:

Lead ☐ No ☐ Yes: Date- _____ Vision Screen ☐ No ☐ Yes: Date- _____

Hemoglobin ☐ No ☐ Yes: Date- _____ Hearing Screen ☐ No ☐ Yes: Date- _____

Medications: _____

Limitations for school or health conditions (including food supplements, modified diets, activity restrictions, and health services):

_____

Please attach a copy of the most recent Immunization record
(required by Section 3313.671 of Ohio Revised Code and for attendance in preschool)

Exempt from immunizations: ☐ Religious Convictions ☐ Health Concern ☐ Other

I have examined this child and found he/she is in suitable condition for participation in group care.

_____ _____

Signature of Physician/Physician's Assistant/Clinical Nurse Specialist/Certified Nurse Date of Exam

Printed Name:_____

Address: _____

Phone: (_____)_____-_____ FAX: (_____)_____-_____