Child's Medical Statement
Good Samaritan School

Revised: 6/12

Identifying Data:

Child's Name_____ Age:_____ D.O.B._____

Parent's Name(s)_____ Grade: _____

Address:_____

Immunization:

This is to certify that I have examined_____ on _____ and have found that s/he:
(child's name) (date)

has had the immunizations required by SECTION 3313.671 of the OHIO REVISED CODE for admission to school, or has had the immunization required by the OHIO DEPARTMENT OF HEALTH for infants and toddlers, or _____ is to be exempted from these requirements for medical or religious reasons.

DTaP/TD	1	2	3	4	5*
POLIO	1	2	3	4*	
HEP B	1	2	3		
MMR	1	2			
HIB	1				
VARICELLA	1	2			
OTHER					

*The 5th DTaP and 4th Polio should be administered just prior to preschool or school entrance.

General Physical Examination:

Skin_____ Head_____ Eyes_____ Ears_____ Nose_____
Teeth_____ Neck_____ Chest_____ Lungs_____ Back_____
Abdomen_____ Genitalia_____ Extremities_____ Allergies_____ Lymphatics_____
Heart_____

Blood Pressure: _____/_____
Height: _____' _____"
Weight: _____lbs. _____oz.

Lab Work (Optional):

HGB_____ or HCT_____ (fingerprick)
Urine:_____
Lead:_____
Other Labs Authorized: _____

Vision:

Speech and Hearing:

Please Continue on Backside

General Neurological Examination:

Gait_____ Station_____ Muscle Power_____
Muscle Tone_____ Reflexes_____ Cranial Nerves_____

Motor Abnormalties:_____

Gross Motor Coordination:_____

Fine Motor Coordination:_____

Sensory Abnormalities:_____

Behavioral Problems: (check if observed or reported by informant)

☐ Hyperactive ☐ Withdrawn ☐ Short attention span ☐ Disturbed Sleep Pattern

☐ Distracted ☐ Other (please describe)_____

Comments:

Abnormal Conditions/Disabilities:

Asthma/Allergies (Specify):

Current Medications:

Special Diets:

This is to certify that the above-named child has had a complete physical examination. This child is free from apparent communicable disease and is in suitable condition to attend a preschool program, based on his/her medical history and physcial condition at the time of this exam.

Physician's Signature_____ **Date**_____

Physician's Printed Name_____

Address:_____

_____

Telephone Number_____ **Fax Number**_____

Parent/Guardian Signature_____ **Date**_____