Child's Medical Statement

Identifying Data

Child's Name: ______________________________

Age: ______________ Date of Birth: ______________ Grade: ______________

Parent's/Guardians Name(s): ______________________________

Address: ______________________________

Immunization

This is to certify that I have examined ______________ (Child's Name) on ______________ (Date) and have

Found that s/he: 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.		
MMAR	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

____
____
____

General Neurological Examination

Gait	______	Station	______	Muscle Power	______
Muscle Tone	______	Reflexes	______	Cranial Nerves	______

Motor Abnormalities: ______________________________
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- ☐ Withdrawn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: ______________________________

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 physical condition at the time of this exam.

Physician's Printed Name: ______________________ Date: __________
Physician's Signature: ______________________________
Address: ______________________________
Telephone Number: ______________________ Fax Number: __________
Parent/Guardian Signature: ______________________ Date: __________