Summit Preschool Student Medical Statement

(Completed by a Doctor or Physician)

Return to : 420 Washington Ave. Cuyahoga Falls, Ohio 44221 Phone: 330-945-5600 Fax 330-945-6222

Student Full Name ______________________ Date of Birth ______________

Required Screeing

Height:______________________

Weight:______________________

Blood Pressure: ______________________

Vision:

Stereopsis (PASS 2) Pass Non-Pass

Distance Acuity: 5 ft. crowded LEA or other

Right eye	Pass	Non- Pass
Left Eye	Pass	Non-Pass

Hearing:

Pass	RT	LT	Both
Non-Pass	RT	LT	Both

Laboratory Test:

	Date	Results
Lead Level*		
Hematocrit*		

*Lab test only required upon entry into preschool program.

Exam Results:

	Normal	Abnormal	Not Examined
General Appearance			
Posture, Gait			
Behavior			
Skin			
Hair			
Eyes: External			
Eyes: Optic Fundi			
Ears: External & Canals			
Ears:Tympanic Membranes			
Nose, Mouth, & Pharynx			
Teeth			
Heart			
Lungs			
Abdomen(include hernias			
Genitalia			
Bones, Joints, Muscles			
Neurological			

Please summarize abnormal findings including chronic physical problems, hospitalizations, or diseases.

List treatment plan, services (therapy, medication, referrals):

List Food Allergies, Restrictions or Modified Diets:

List all Allergies/Treatment (include drug allergies):

IMMUNIZATION RECORD:

Exempt from Immunizations:

Medical/health concern:

Yes No

~Rationale: ______________________

Immunizations: (Page 2)

Attached Written on back

Date of Exam: ______________________

Physical exam must have been done in the last 13 months and must be updated yearly for preschool.

Health Care Provider's Signature **Date**

Please Validate with Stamp (Clinic name, address, phone)

Based upon the medical history and physical condition at the time of this examination, he/she is free from communicable diseases including Tuberculosis; and has received immunizations required by statute for admission to school under Section 3313.671 of the Revised Code, or has had the immunizations required by the State Department of Health for infants and toddlers. In addition the child is in suitable condition for enrollment in a day care center.

*Additional forms may be required to address health concerns (e.g. medication, treatments, diet)

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Summit Preschool Medical Statement (Continued, Page 2)

Student Full Name ________________________________ Date of Birth ________________________

Immunization Record: (Please Fill in or attach printed copy)

Vaccine		Date (Month/Year)				
DPT						
Polio						
MMR						
Hepatitis A						
Hepatitis B						
Varicella						
HIB						
Pheumococcal						
Influenza (flu)						
Other:						