Perrysburg Preschool
Preschool Medical Assessment
(Required of ALL children every 13 months)

Child_____ ☐ F ☐ M **DOB:** _____

Parent/Guardian: _____

REQUIRED INFORMATION
PLEASE READ THIS BEFORE FILLING OUT FORM

DOCTOR/NURSE/OFFICE STAFF: Ohio requires that ALL INFO in this section MUST be completely filled out, or the form will be returned to the parent.

PARENTS: Please review this form BEFORE you leave the office to verify all into is complete and form is signed/dated. If this form is turned in to the school incomplete, it will be returned to you to take back to the doctor's office.

NOTE: If you mark "No" you MUST √ a reason In one the right-hand columns				Reason not completed (Check which applies)	
Assessments/ Screenings	**Completed?**	**Date Completed**	**Results**	**Examples: religious convictions, insurance coverage, other**	**Health professional decision**
Hemoglobin*	☐ Yes → ☐ No →		Check reason HMG was not tested: →		
Lead*	☐ Yes → ☐ No →		Check reason lead was not tested: →		
Vision	☐ Yes → ☐ No →		Check reason vision was not tested: →		
Hearing	☐ Yes → ☐ No →		Check reason hearing was not tested: →		

Child's Height: _____ **Child's Weight:** _____

**Note: If hemoglobin were checked when the child was younger, they are generally not checked again before kindergarten unless the physician has a concern. Please enter previous date completed and results

Physical Assessment

Optional	Date	Results
TB		
Urinalysis		
Speech		

Does this child have any of the following?

- ☐ Heart condition/high blood pressure? Explain: _____ _____
- ☐ Neurological condition, seizures, tumor, trauma, etc.? Explain: _____ _____
- ☐ Orthopedic condition? Please indicate if the child has atlantoaxial dislocation for children with Down Syndrome. Explain: _____ _____

Child's Name: _____

REQUIRED IMMUNIZATIONS

This is to certify that I have examined this child and have found that: This child has had the immunizations required by Section 3313.671 of the Revised Code for admission to school, or has had the immunizations required by The State Department of Health for Infants and Toddlers, or is to be exempted from these requirements for medical reasons.

Immunization	Date	Date	Date	Date	Date	Comments
DTP	*	*	*	*		5th DPT administered between 4-6 years
OPV	*	*	*			4th OPV administered between 4-6 years
HIB	*	*	*	(*hibiter)		3 doses for pedvax 4 doses for hibiter
MMR	*		Measles	Mumps	Rubella	2nd dose by Kindergarten entry
Hep B	*	*	*			

*Immunizations required before starting preschool

Indicate any limitations or modifications of the child's participation in daily child care or any special treatments. _____
_____

Are any activities contraindicated for this child?

☐ Running ☐ Rotary Vestibular Stimulation ☐ Swinging ☐ Somersaults
☐ Rolling, rocking ☐ Prone or supine activities ☐ Ranging of motion to all joints
☐ Other
Additional comments: _____
_____

If child is determined to need Occupational Therapy Assessment/treatment, may we proceed? ☐ Y ☐ N

Allergies: _____

Allergy to latex? ☐ Y ☐ N

Medications: _____
_____

Based upon medical history and physical condition at the time of this examination, this child is free from apparent communicable disease and is in suitable condition for enrollment in a child care facility.

Please type or print name of provider

Physician's Name: _____ Phone: _____
Street Address: _____
City, State, Zip: _____

SIGNATURE OF EXAMINING: _____ DATE OF EXAM: _____
(check one) ☐ Physician ☐ Physician's Assistant ☐ Advanced Practice Nurse