Our Lady of Perpetual Help Preschool

Child Medical Statement

Please complete ALL pages of the form

Revised 4/11/17

Section I – Child Medical Information

Child's Name _____

Date of Birth _____ Height _____ Weight _____

Immunizations:			**Exempt from Immunization:**		
Complete for Age	☐ Yes	☐ No	Religious Conviction	☐ Yes	☐ No
In Process	☐ Yes	☐ No	Health	☐ Yes	☐ No
			Other _____		

Limitations or Health conditions, including allergies, medications, and dietary restrictions

Section II – Child Medical Statement Verification

Physician/Clinic/Hospital Name _____ Provider Phone Number _____

Provider Address _____

Provider City _____ Provider State _____ Provider Zip _____

Check box of examining medical professional:

- ☐ Physician
- ☐ Physician's Assistant
- ☐ Advanced Practice Nurse

This child has been examined and is in suitable condition to participate in group care.

Signature of Medical Professional	*Date of Exam*
X _____	

Programs funded through the Ohio Department of Education must have written policies and procedures to ensure that children have received comprehensive health screenings and/or that families are informed of the importance of health screenings and the resources to obtain them.

Section III – Recommended Immunizations

Please enter the month, day, and year in each box – **OR** – printed immunization record may be attached instead of completing below.

Vaccines	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5
Diphtheria, Tetanus, Pertussis (DTaP)					
Hepatitis B (Hep B)					
Haemophilus Influenza type b (HIB)					
Measles, Mumps, Rubella (MMR)					
Inactivated Polio					
Varicella (chicken pox)					
Influenza					
Pneumococcal Conjugate (PCV)					
Rotavirus					
Hepatitis A					
Other					
The immunizations above are recommended by the Centers for Disease Control and Prevention and the Ohio Department of Health.					

Section IV – Additional Information

The information below is **ONLY** necessary for children enrolled in:

≈ Early Childhood Education Grant Program

≈ Preschool Special Education Program

If your child is NOT in one of the two programs above, the information below is not necessary.

			Reason Not Completed *(please indicate which applies)*	
Assessment/ Screenings	Completed?	Date Completed	Health Professional Decision	Other *(examples: religious conviction, insurance coverage, other)*
Vision	☐ Yes ☐ No			
Hearing	☐ Yes ☐ No			
Dental	☐ Yes ☐ No			
Lead	☐ Yes ☐ No			
Hemoglobin	☐ Yes ☐ No			