# *PERRYSBURG EXEMPTED VILLAGE SCHOOL DISTRICT*

## 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<br>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

11/16/16