Child Medical Statement/Preschool Physical

Fort Recovery Public Preschool 419-375-4131

Child's Name _____ **Date of Birth** _____

Height _____ **Weight** _____ **Blood Pressure** _____

Limitations of health condition (including allergies, medications, dietary restrictions)

Immunizations	Please circle one	
Complete for age	Yes	No
In Process	Yes	No

Exempt from Immunizations	Please circle one	
Religious Conviction	Yes	No
Health Concern	Yes	No
Other:		

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

Signature of examining Physician/Physicians Assistant or Advance Practice Nurse (circle one) Address: Phone:	Date of exam

Required for children enrolled in an Early Childhood Education Grant Program			**State reason not completed**
			Health Professional Decision, Religious conviction. Insurance coverage or other
Assessments/Screenings	**Date Completed**	**Findings**	
Lead			
Hemoglobin			
*Vision			
*Hearing			
*Speech			
*Language			
**Dental			

*Additional screenings to be done at school.

**Dental screening to be completed by dentist.