



PRESCHOOL MEDICAL RECORDS FORM
(THIS FORM MUST BE COMPLETED BY A PHYSICIAN)

Child's Name: Last First Middle Birth date:

Address: Home Phone:

Parent(s) Name: Father: Mother:

Guardian(s):

EXAMINATION

For children three years or older at the time of school admission the examination shall occur within the twelve months prior to admission (O.R.C. 3301-37-05)

Date: B.P. Weight: Vision: R. 20/ L. 20/
Eyes: Hearing Test: Yes No
Ears: Hearing Results: R. L.

Nose: Throat:
Mouth: Teeth:

Is dental work indicated?
If yes, are plans being made?

Posture: General Condition:
Skin: Orthopedic:
Neck: Nervous System:
Heart: Lungs:
Abdomen: Hernia:
Genitalia: Urinalysis:

Remarks and recommendations:

IMMUNIZATION (Enter month/day/year of each immunization)

DPT: 1 2 3 4 5\*
POLIO: 1 2 3 4
MMR: 1 2
If separate: Measles: Mumps: Rubella
HIB: 1 2 3 4
Hepatitis B: 1 2 3
Varicella 1 2

Other Immunizations: (Give type and date):

Tuberculin test Date: Results:

I certify that this child has been examined and is in suitable condition to participate in group care. I certify that they have had the above immunizations.

Signature of Physician: (required)

Date: Telephone: