Educating Excellence! Riverside Local Schools

Riverside Local Schools

Preschool Medical Statement

This medical statement must be completed by the student's physician within 13 months of the student's first day of school, and completed every 13 months after this initial exam while attending our program.

1. Based on his/her 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 preschool program. *As required by Ohio Revised Code Rule 3301-37-08,* ***the child must be examined within thirteen months prior to the date of admission.***

Child's Name: ______________________________________ Birth Date:______________________

Present Age: ______________________________________ **Exam Date**:______________________

Gender: ______________ Height ______________ Weight__________________

Vision screening date_______________ (if applicable) Hearing screening date_______________ (if applicable)

2. This is to certify that I have examined this child and found that: This child has had the immunizations required by section 3313.571 of the Ohio Revised Code for admission to school, or has had the immunizations required by the state department of health according to the child's age, or is to be exempted from these requirements for medical or religious reasons.

IMMUNIZATION RECORD: (Enter month/day/year of each immunization)				
DTP	**Polio**	**HIB**	**MMR**	**HEP B**
1.	**1.**	**1.**	**1.**	**1.**
2.	**2.**	**2.**	**2.**	**2.**
3.	**3.**	**3.**		**3.**
4.	**4.**	**4.**	**TB Test**	**Varicella**
5.			**1.**	**1.**

☐ The parent has declined to have the child immunized and they will provide the required exemption form.

Name of Physician (or stamp) ____ Phone: ______________________

Street Address: ____

City: ____ State: __________ Zip Code: ____________________

____ ____________________________

Examining Physician's Signature Date

DENTIST INFORMATION TO BE COMPLETE BY THE PARENT/LEGAL GUARDIAN

Name of Physician (or stamp) ____ Phone: ______________________

Street Address: ____

City: ____ State: __________ Zip Code: ____________________