



# North Central Ohio Educational Service Center

**Integrated Preschool Program  
Child Medical Statement  
(Required of ALL children every 13 months)**

<b>Child's Name</b>	<b>Date of Birth</b>
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### Required Information

\*Please Read Before Filling Out This Form\*

**Doctor/Nurse/Office Staff:** Ohio requires that ALL INFO in this section must be completely filled out, or this form will be returned to the parent.

**Parents:** Please review this form **BEFORE** you leave the office to verify all information is complete and the form is signed and 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 of 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 <input type="checkbox"/>				
	No <input type="checkbox"/>	Check a reason HM G wasn't tested: <input type="checkbox"/>			
Lead*	Yes <input type="checkbox"/>				
	No <input type="checkbox"/>	Check a reason Lead wasn't tested: <input type="checkbox"/>			
Hearing	Yes <input type="checkbox"/>				
	No <input type="checkbox"/>	Check a reason Hearing wasn't tested: <input type="checkbox"/>			
Vision	Yes <input type="checkbox"/>				
	No <input type="checkbox"/>	Check a reason Vision wasn't tested: <input type="checkbox"/>			

Child's Height \_\_\_\_\_

Child's Weight \_\_\_\_\_

\* Note: If Hemoglobin and/or Lead 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.

#### Limitations or Health Conditions (Allergies, Medications, Dietary Restrictions, Etc.)

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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 a preschool setting.**

Physician's Name \_\_\_\_\_ Address \_\_\_\_\_

Signature of Examining \_\_\_\_\_

(Check One)

Physician

Physician's Assistant

Advanced Practice Nurse

Date of Exam \_\_\_\_\_