**Lima City Schools Preschool**
**925 East Third Street**
**Lima, Ohio 45804**
**Fax: 419-996-3301**
**Preschool Office Phone: 419-996-3692**

Dear Physician:

This letter is accompanying our physical form Lima City Schools Preschool Program. This form is mandated by the State of Ohio to be completed prior to a child starting in out preschool program.

**We must have the following information provided by your office:**

- **Height and Weight**
- **Immunization Records**
- **Lead and Hematocrit Level***
- **Physicians signature indicating child is free of communicable diseases**

We are required to have these results in the child's personal file that is inspected by the Ohio Department of Education Licensure Personnel.

If you have any questions about the physical, please contact Angela Miller, Lima City Schools Preschool Director, at 419-996-3427. Thank you for your help and cooperation in this matter.

Sincerely,

*Angela Miller*

Angela Miller
Preschool Director

OHIO DEPARTMENT OF EDUCATION
DIVISION OF EARLY CHILDHOOD EDUCATION
EARLY CHILDHOOD EDUCATION SECTION

# CHILD'S MEDICAL STATEMENT

This is to certify that I have examined _____ on _____
(Child's Name) (Date)
and have found that he/she:

1) Has had the immunizations required by SECTION 3313.671 of the OHIO REVISED CODE for admission to school or has had the immunizations required by the OHIO DEPARTMENT OF HEALTH for infants and toddlers, or
_____ is to be exempted from these requirements for medical or religious reasons.

IMMUNIZATION RECORD: Enter month/day/year for each immunization.

| | | | | | |
|---|---|---|---|---|---|
| HEP B | 1 | 2 | 3 | | |
| DTP | 1 | 2 | 3 | 4 | 5* |
| POLIO | 1 | 2 | 3 | 4* | |
| MMR** | 1 | | | | |
| HIB | 1 | | | | |
| ROTAVIRUS (recommended) | 1 | 2 | 3 | | |
| | | | | | |

** If measles, mumps, rubella not given as MMR, give dates for each immunization.

Measles _____ Mumps _____ Rubella_____

* The 5th DTP and 4th Polio should be administered just prior to preschool or school entrance.

2) **Is free from apparent communicable disease and is in suitable condition to attend a preschool program based on his/her medical history and physical condition at the time of this examination.**

| | |
|---|---|
| **Physician's Signature** | |
| **Physician's Name (Please Print)** | |
| Address | |
| City, State, Zip Code | |
| Phone | |
| Parent Name | |
| Child's Birth Date | |

| | |
|---|---|
| Physician's Name | |
| Date of Examination | |
| Child's Name | |
| Child's Birth Date | |

PHYSICAL ASSESSMENT: Did the examination reveal **any abnormalities** in the following areas?

| | YES | NO | FINDINGS |
|---|---|---|---|
| General Appearance | | | |
| Skin | | | |
| Lymph Nodes | | | |
| Eyes | | | |
| Ears | | | |
| Nose/Throat | | | |
| Teeth/Gums/Tongue/Palate | | | |
| Heart | | | Blood Pressure: |
| Lungs | | | |
| Abdomen | | | |
| Genitalia | | | |
| Skeletal System | | | |
| Neuro Muscular | | | |
| Allergies | | | Type:<br><br>Treatment: |

REQUIRED SCREENINGS: Please indicate the results of any screenings:

| Screening | Date | Results | Follow-up Required? (When) |
|---|---|---|---|
| Vision [@2 yrs. beg. at age 3] | | | |
| Hearing [@2 yrs. beg. at age 3] | | | |
| Speech | | | |
| Hematocrit ***Results Required** | | | |
| Height | | | |
| Weight | | | |
| Lead ***Results Required** | | | |
| TB* | | | |
| Urinalysis | | | |
| Other: Sickle Cell, Etc. | | | |

RULE 3301-37-05 OF THE ADMINISTRATIVE CODE REQUIRES PRESCHOOL PROGRAMS TO SECURE HEALTH INFORMATION FROM A CHILD'S PARENT NO LATER THAN THE FIRST DAY OF ATTENDANCE UNLESS OTHERWISE INDICATED.

| | |
|---|---|
| Name of Child (Please Print) | |
| Date of Birth | |
| Parent(s)/ Guardian Name | |
| Child's Height | |
| Child's Weight | |
| Child's Current Age | |

| | |
|---|---|
| Allergies affecting child | |
| Special precautions and/or treatment for allergies | |
| Medications (prescriptions or over the counter) child is currently receiving. List dosages, times of day medication is usually given, and the reason for the medication. | |
| Chronic physical problems affecting child | |
| Date(s) of hospitalizations and reason(s) why child was hospitalized (each time). | |
| List the diseases the child has had to date. | |
| List any food supplements, modified diets, or fluoride supplements currently required. | |

**This information was provided by the following individual:** _____

**Date form completed:** _____