

Holy Trinity Preschool
740 Tiffin St.
Bucyrus, Ohio 44820

CHILD'S MEDICAL STATEMENT

This is to certify that I have examined _____
on _____ and have found that he/she:
date

Child's name

1) has had the immunizations required by Section 3313.671 of the Revised Code for admission to school, or has had the immunizations required by the State Department of Health for infants and toddlers, or is to be exempted from these requirements for medical reasons.

Immunization Record:

Enter month/day/year of each immunization

DPT: 1 _____ 2 _____ 3 _____ 4 _____ *5 _____

POLIO: 1 _____ 2 _____ 3 _____ 4 _____

Measles, mumps, rubella- usually combined as MMR _____

If separate, measles _____ mumps _____ rubella _____

*The 5th DTP and 4th polio are normally administered just prior to kindergarten.

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

Physician's Name	Signature	Parent's name
Street Address		Child's Birth date
City, State, Zip Code	Phone	

CHILD'S HEALTH AND GENERAL INFORMATION SHEET

Rule 3301-37-05 of the Administration Code require the preschool program to secure information from a child's parent no later than the first day of attendance unless otherwise indicated.

Child's name: _____ Birthdate: _____

Address: _____ Phone: _____

Name of Parent (s)/Guardian: _____

Child's Height _____ Weight _____

1) Does your child have any physical problems that we should be aware of (for example – hearing, speech, or vision problem?)

2) Allergies (List all allergies affecting the child and any other special precautions or treatments indicated for these allergies.)

3) Medications (List all medications currently being administered to the child.) _____

4) Chronic Physical Problems (List all chronic physical problems affecting the child.) _____

5) History of Hospitalizations (List dates of all hospitalizations of the child.) _____

6) Diseases (List all diseases the child has had.) _____

Immunization Record: Enter month/day/year of each immunization

DPT: 1 _____ 2 _____ 3 _____ 4 _____ *5 _____ POLIO: 1 _____ 2 _____ 3 _____ 4 _____

Measles, mumps, rubella– usually combined as MMR _____ If separate, measles _____ mumps _____ rubella _____

HIB – d: 1 _____ 2 _____ 3 _____ Other: _____

*The 5th DTP and 4th polio are normally administered just prior to kindergarten.

7) Has your child attended a nursery school prior to this one? _____ If yes, where? _____

8) Does your child have playmates his/her own age? _____

9) Does your child have a hobby or special interest? _____

10) Does your child have any fears we should be aware of? _____

11) Does your child have an older brother or sister at this school? _____ If yes, please list name & grade.

12) Add any additional comments or information about your child that you think might be helpful: _____
