WARREN CITY SCHOOL DISTRICT
CHILD MEDICAL STATEMENT

Child's Name: ____ **Birth Date:** ____________________
Please Print

This is to certify that I have examined this child and his/her health records and found the following:

1. This child has had the immunizations required by section 3313.671 of the Revised Code for admission to school, or has had the immunizations recommended by the State Department of Health according to the child's age, or is to be exempted from these requirements for medical reasons.

Please note exemptions:____
____

IMMUNIZATIONS(*) ENTER MONTH, DAY AND YEAR					
Vaccine	**Dose 1**	**Dose 2**	**Dose 3**	**Dose 4**	**Dose 5**
Diphtheria, Tetanus, Pertussis (DTaP)					
Hepatitis B (Hep B)					
Haemophilus Influenza Type B					
Measles, Mumps, Rubella					
Inactivated Polio					
Varicella (chicken pox)					
Influenza					
Pneumococcal Conjugate (PCV)					

***The immunizations above are recommended immunizations. Please consult your physician for more information.**

2. Based on medical history and physical condition at the time of this examination, this child is in suitable condition to attend a preschool program.

3. List any limitation of health conditions (including allergies, daily medication, dietary restrictions)
   ____
   ____

Recommended Assessments/Screenings:

Vision Yes ☐ No ☐ Date:	**BMI** Yes ☐ No ☐ Date:
Hearing Yes ☐ No ☐ Date:	**HEMOGLOBIN** Yes ☐ No ☐ Date:
Dental Yes ☐ No ☐ Date:	**HEMATOCRIT** Yes ☐ No ☐ Date:
	LEAD Yes ☐ No ☐ Date: ***PROOF REQUIRED FOR LEAD, HEMOGLOBIN, & HEMATOCRIT TEST***
Signature of examining Physician/Certified Nurse Practitioner	**Date of Examination**

Ohio Administrative Code rules 5101:2-12-37 and 5101-2-13-37 require that this examination be given no more than twelve months prior to the date of admission to the child care facility and every 13 months thereafter for children who are 3 years old and older.

Name of Physician/Certified Nurse Practitioner ____ Date __________________

Street Address ____ City/State/Zip _________________________