Wood County Preschool Program

Please complete both sides

Preschool Medical Assessment

(Required of ALL children every 13 months)

_______________ Child _______________ DOB ❒ M ❒ F _______________ Parent/Guardian

— ALL INFORMATION IN THIS BOX IS REQUIRED —

DOCTOR/NURSE: **ALL INFO** in this box **MUST** be completely filled out.

PARENTS: Please review this form **BEFORE** you leave the office to verify all info in this box is complete and the form is signed/dated. **If this form is incomplete it will be returned to you to take back to the doctor's office.**

NOTE: If you mark "No" you MUST choose a reason why

Was HEMOGLOBIN* checked? ❒ **Yes** ❒ **No** **If Yes, record date** ________ **& Results** ________
If No, reason why: ❒ Health professional's decision ❒ No concerns ❒ Religious convictions, insurance, other

Was LEAD* checked? ❒ **Yes** ❒ **No** **If Yes, record date** ________ **& Results** ________
If No, reason why: ❒ Health professional's decision ❒ No concerns ❒ Religious convictions, insurance, other

Was VISION tested? ❒ **Yes** ❒ **No** **If Yes, record date** ________ **& Results** ❒ WNL or: ________
If No, reason why: ❒ Age (too young) ❒ Health professional's decision ❒ Religious convictions, insurance, other

Was HEARING tested? ❒ **Yes** ❒ **No** **If Yes, record date** ________ **& Results** ❒ WNL or: ________
If No, reason why: ❒ Age (too young) ❒ Health professional's decision ❒ Religious convictions, insurance, other

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. If so, please enter previous date completed and results.

PHYSICAL ASSESSMENT

Optional	Date	Results
TB		
Urinalysis		
Speech		

Does this child have any of the following?

❒ Heart condition/high blood pressure? Explain: ________________

❒ Neurological condition, seizures, tumor, trauma, etc? Explain: ________________

❒ Orthopedic condition? Please indicate if the child has atlantoaxial dislocation for children with Down Syndrome. Explain: ________________

- PLEASE ATTACH CHILD'S IMMUNIZATION RECORD -

IMMUNIZATIONS

❐ Yes ❐ No This above-named child has been examined, the immunization status recorded, and the child is in suitable condition for participation in group care.

❐ Yes ❐ No This above-named child has been immunized in accordance with the requirements of section 5104.014 of the Ohio Revised Code (please note any exceptions below).

Exceptions to Immunization requirements pursuant to 5104.014 ORC (please include names of requirement diseases against which the child has not been immunized and whether it is because the immunization is medically contraindicated, not medically appropriate for the child's age, or declined by the parent).

I have declined to have my child immunized against one or more of the diseases required by 5104.014 of the Ohio Revised Code. Please note disease above and sign.

Signature of Parent ____________________________ Date of Signature ____________________

OTHER

Indicate any limitation or modifications of the child's participation in daily child care or any special treatments. ____________________

____

Are any activities contraindicated for this child?

❐ Running ❐ Rotary Vestibular Stimulation ❐ Swinging ❐ Rolling, rocking
❐ Somersaults ❐ Prone or supine activities ❐ Range of motion to all joints ❐ Other

Additional comments: ____

If child is determined to need Occupational Therapy Assessment/treatment, may we proceed? ❐ Yes ❐ No

Allergies: ____
Allergy to latex? ❐ Yes ❐ No

Medications: ____

Based upon his 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 child care facility.

Please type or print name of provider

Physician's Name ____________________________ Phone ____________________

Street Address ____

City, State, Zip ____

SIGNATURE OF EXAMINING ____________________________ **DATE OF EXAM** ____________________
(check one) ❐ Physician ❐ Physician's Assistant ❐ Advanced Practice Nurse

Parents: If you pick up this form from the doctor's office, please give it to your child's teacher or you/the doctor may mail, fax, or scan/email it to:

Wood County ESC
1867 North Research Drive
Bowling Green, Oh 43402

FAX #: 419-354-1146
(Attn: PS Secretary)

or email to:
nstickles@wcesc.org