WOOD COUNTY EDUCATIONAL SERVICE CENTER
Wood County Preschool Program

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* checked? ❒ 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* checked? ❒ 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. 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: __________

Preschool Medical Assessment (cont'd)

Child's Name: ______________________________

- 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 ______________________________ FAX ____________________

City, State, Zip ______________________________

SIGNATURE OF EXAMINING ______________________________ **DATE OF EXAM** ____________

(check one) ❒ Physician ❒ Physician's Assistant ❒ Advanced Practice Nurse

Parents: If you pick up form from dentist, please give to your child's teacher or you/dentist may send it to:

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

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

or email to:
nstickles@wcesc.org