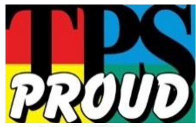

Toledo Public Schools
Early Childhood Education

Phone: 419-671-_________ Fax: 419-671-________

Child Medical Statement

Office Use Only	Peer ____	EH ____
Teacher ______________________________________		
School _______________________________________ AM PM		

Ohio Administrative Code 5101:2-12-37 requires that this exam be given no more than twelve months prior to the date of admission to Toledo Public Schools Early Childhood Program.

Child Name ____

EXAM DATE: _____ / _____ / _____

Date of Birth _____ / _____ / _____

REQUIRED SCREENINGS
Ohio EPSDT Requires ALL Screenings

HT: ___________________ **WT:** ____________________

BP: ___________________ **HGB/HCT:** ______________

HEARING: R _______________ **L** _________________

VISION: R _______________ **L** _________________

LEAD: MOST RECENT DATE:___________ **RESULT:**___________

Comprehensive Physical Examination
At each visit, age-appropriate physical examination is essential, with infant totally unclothed and older children undressed and suitably draped.

Chronic Problems – Under Treatment
- □ Anemia
- □ Hearing Difficulties
- □ Vision Problems
- □ Asthma
- □ Diabetes
- □ High Lead Level
- □ Allergies or special diet : ___________________________
- □ Medications: ____________________________________
- □ Other:____
- □ Other:____

Abnormal Findings at Exam	Plan of Action	Referral? To Whom?

Immunizations – Attach a printed record of the following immunizations including the date of each.

- DTaP
- Hep B
- HIB
- MMR
- IPV
- Varicella
- Hep A
- PCV/Prevnar
- ROTA
- Influenza

- If this child should be exempt from immunizations, please list the reason(s):

____

Influenza Vaccine: IF NOT GIVEN
- □ Seasonal (not available)
- □ Parent Declined – Parent Signature ____

(only needed if declined)

Guardian signature on this form indicates that guardian has declined to have the child immunized against influenza due to reasons of conscience, including religious convictions, per ORC 5104.014. All other exemptions must be submitted on a State of Ohio Legal Immunization Exemption Form.

Indicate any special precautions needed during **bus transportation:** ____

This is to certify that I have examined this child and found that:

1. This child has been immunized against or is in the process of being immunized against the immunizations required by ORC 5104.014 according to the child's age or is to be exempted from these requirements for the reason(s) listed above.
2. ANTICIPATORY GUIDANCE has been provided to parent through discussion or handouts and a Medical/Family/Social history is reviewed at each Well Child Examination.
3. Based upon medical history and physical condition at the time of this examination, this child is in suitable condition to participate in group care and/or TPS Early Childhood Programs.

____ **Printed Physician Name:** ____________________________________

PHYSICIAN SIGNATURE ***** Date of examination**

Address: ____

Phone: ____ **Fax:** ____