



Sandusky City Schools

Pre-School/Pre-Kindergarten Medical Evaluation 2009-2010 School Year

Please return to: 407 Decatur Street, Sandusky, Ohio 44870-2442
 Phone: 419-626-6940 Fax: 419-609-4402

Student Name: _____ DOB: _____
 Parent/Guardian Name: _____ Phone: _____
 Address: _____ City/Zip: _____

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

- This child has had the immunizations required by section 3313.671 of the Ohio Revised Code for admission to school, or has had the immunizations recommended by the Ohio 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, year)					
Vaccine	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5
Diphtheria, Tetanus, Pertussis (Dtap)					
Hepatitis B (Hep B)					
Haemophilus Influenza type b (HiB)					
Measles, Mumps, Rubella (MMR)					
Inactivated Polio					
Varicella (chicken pox)					
Influenza					
Pneumococcal Conjugate (PCV)					
Other:					

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

- Based upon medical history and physical condition at the time of this examination, this child is in suitable condition for participation in group care.
- List any limitations or health conditions (including allergies, daily medications, dietary restrictions): _____

Recommended Assessments/Screenings:

Vision <input type="checkbox"/> No <input type="checkbox"/> Yes Date: _____ Dental <input type="checkbox"/> No <input type="checkbox"/> Yes Date: _____ BMI <input type="checkbox"/> No <input type="checkbox"/> Yes Date: _____	Hearing <input type="checkbox"/> No <input type="checkbox"/> Yes Date: _____ Lead <input type="checkbox"/> No <input type="checkbox"/> Yes Date: _____ Other: <input type="checkbox"/> No <input type="checkbox"/> Yes Date: _____
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Signature of examining Physician/Certified Nurse Practitioner:	Date of examination:
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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.

Printed Name of Physician/Certified Nurse Practitioner:	Phone:
Street Address:	
City/State/Zip Code:	