Pickerington Preschool
Health Record

(Parent completes top section)

Child's Name _____ Sex _____ Date of Birth _____

Physician's Name _____ Phone _____

Health History

List any medication child is taking _____

List any food and/or drug allergies _____

List any ongoing physical problems _____

List any diseases, hospitalizations or surgeries _____

Medical Statement

(Physician completes this section)

Date of exam (must be within the last 12 months) _____

Height _____ Weight _____ Blood Pressure _____

Based upon medical history and physical condition, is this child in suitable condition for preschool enrollment? Yes _____ No _____

Immunization Record (enter month, day, and year of each immunization)

DPT 1. _____ 2. _____ 3. _____ 4. _____ 5. _____

Polio 1. _____ 2. _____ 3. _____ 4. _____

MMR 1. _____ If separate, measles _____, mumps _____, rubella _____,

HIB 1. _____ 2. _____ 3. _____ 4. _____

Other (Tuberculin,etc.) _____

HEP B 1. _____ 2. _____ 3. _____

Exempt from Immunizations: Please check one

Religious Conviction Yes ☐ No ☐

Health concern Yes ☐ No ☐

Other: _____

_____

X_____

Signature of examining (check one)

☐ Physician ☐ Physician's Assistant ☐ Advanced Practice Nurse

Address: _____

Phone: _____ Date of exam _____

Required for children enrolled in an Early Childhood Education Grant Program or Preschool Special Education Program			Reasons Not Completed (answer all that apply)	
Assessments/ Screenings	Completed **Please check one**	Date Completed	Examples: religious conviction insurance coverage, other	Health professional decision
Vision	☐ Yes ☐ No			
Hearing	☐ Yes ☐ No			
Dental	☐ Yes ☐ No			
Lead	☐ Yes ☐ No			
Hemoglobin	☐ Yes ☐ No			