518 S 8th St
Cambridge, OH 43725

(phone) 740-439-7592
(fax) 1-800-521-6763

# Child Medical Statement

**PARENT, PLEASE COMPLETE RED BOXED AREA THEN GIVE TO PHYSICIAN.**

Child's Name _____ DOB _____

By signing below, I authorize my physician, _____, to release the completed medical statement and any communicable disease diagnosis during this school year to Cambridge Preschool.

_____

Parent/Guardian Signature Date

**Required for ALL children enrolled in Preschool Special Education and Early Childhood Education Grant Programs.**

Date of exam _____

Height _____ Weight _____ Allergies _____ History _____

| | Normal | Abnormal | | Normal | Abnormal |
|---|---|---|---|---|---|
| General Appearance | | | Glands (Lymphatic?Thyroid) | | |
| Posture, Gait | | | Nose, Mouth Pharynx | | |
| Speech | | | Teeth, Gums | | |
| Head | | | Heart | | |
| Skin | | | Lungs | | |
| Eyes | | | Abdomen | | |
| *symmetrical light reflex | | | Genitalia | | |
| *external aspects | | | Bones, Joints, Muscles | | |
| Development | | | Extremities | | |
| Ears | | | Muscular Coordination | | |
| Social/Emotional | | | Neurological (gross, fine, sensory, motor) | | |

| Assessments/Screening | Completed (please circle one) | Date | Assessments/Screening | Completed (please circle one) | Date |
|---|---|---|---|---|---|
| Lead | Yes No | | Vision screen | Yes No | |
| Hemoglobin | Yes No | | Hearing screen | Yes No | |

Medications_____

**Limitations or health conditions (including food supplements/modified diets, activity restrictions, health services needed at school)**

_____

_____

Immunization record (Required by Section 3313.671 of the Revised Code and for attendance in a preschool program) **Please attach a copy**.

*Exempt from immunizations: _____ Religious conviction _____ Health concern _____ Other

**I have examined this child and found that he/she is in suitable condition for participation in group care.**

_____

Signature Physician/Physician's Assistant/Advanced Practice Nurse Printed Name Date

_____ Address

Telephone Fax