RIVERSIDE LOCAL SCHOOLS
PRESCHOOL PROGRAM
MEDICAL STATEMENT

1. Based on his/her 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 preschool program. *As required by Rules 5101:2-12-37 and 5101:2-13-37, the child must be examined within **thirteen months** prior to the date of admission.*

Child's Name:_____ Birth Date:_____

Present Age:_____ **Exam Date**:_____

Sex: ☐ M ☐ F Height_____ Weight_____

Vision screening date_____ (if applicable) Hearing screening date_____ (if applicable)

2. This is to certify that I have examined this child and found that: This child has had the immunizations required by section 3313.571 of the Ohio Revised Code for admission to school, or has had the immunizations required by the state department of health according to the child's age, or is to be exempted from these requirements for medical or religious reasons. (Please provide documentation for exemptions.)

IMMUNIZATION RECORD: (Enter month/day/year of each immunization)				
DTP	**Polio**	**HIB**	**MMR**	**HEP B**
1.	**1.**	**1.**	**1.**	**1.**
2.	**2.**	**2.**	**2.**	**2.**
3.	**3.**	**3.**		**3.**
4.	**4.**	**4.**	**TB Test**	**Vercelli**
5.			**1.**	**1.**

Name of Physician (please print or stamp)_____ Phone:_____

Street Address:_____ City:_____ State:_____ Zip Code:_____

Signature of Examining Physician _____ **Date:**_____

DENTIST INFORMATION

Name of Dentist (please print)_____ Phone:_____

Street Address:_____ City:_____ State:_____ Zip Code:_____