

# XENIA COMMUNITY SCHOOLS PRESCHOOL

425 Edison Blvd  
(937)562-9706 fax (937)374-4218

## CHILD MEDICAL STATEMENT

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Date of Exam \_\_\_\_\_

### Limitations or Health Conditions (Include allergies, medications, dietary restrictions)

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### Immunizations Please check one and **attach a copy of the child's immunization record.**

Complete for age  Yes  No

In Process  Yes  No

Exemption for health concern  Yes  No

Exemption for religious conviction  Yes  No

### Assessments/Screenings

Required for children enrolled in an Early Childhood Education Grant Program or Preschool Special Education Program	Reason not completed
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Assessment/ Screening	Completed: Please check one	Date completed	Narrate: Religious conviction, insurance coverage etc	Health Professional Decision
Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____		
Hearing	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____		
Dental	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____		
Lead	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____		
Hemoglobin	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____		

This child has been examined and is in suitable condition to participate in group care.

\_\_\_\_\_  
**Signature** of examining (check one)  Physician  Physician's Assistant  Advanced Practice Nurse

Address: \_\_\_\_\_

Phone: \_\_\_\_\_