Hancock County Schools
Preschool Medical Exam Form

Child's name:	DOB:
Parent's name:	School District:

HEALTH ASSESSMENT FINDINGS: *All asterisked items must be completed.

*Height:	*Weight:	Blood Pressure:
*Vision Right: 20/	*Vision Left: 20/	Glasses? ☐ Yes ☐ No
*Hearing Right:	*Hearing Left:	Speech age appropriate? ☐ Yes ☐ No
*List Childhood Diseases:		
*Child's Chronic Illnesses/Hospitalizations:		
*Can the child fully participate in school activities? ☐ Yes ☐ No		
*List Allergies/Specific Precautions and/or Treatments:		
*Current Medications/Modified Diet:		

***REQUIRED IMMUNIZATIONS for PRESCHOOL ADMISSION (Enter Month/Date/Year)**

Vaccine	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5
DTaP/DTP/DT					
Polio					
MMR		2 doses required prior to Kindergarten			
Hib					
HEP B					
Varicella			Not required for PS 2 doses required prior to Kindergarten		

***☐ An additional laboratory screening for Lead has been ordered for this child.**

Based on the medical history and physical condition at the time of this examination, the child is free from apparent communicable disease and has received immunizations required under Section 3313.671 of the Ohio Revised Code and is in suitable condition for enrollment in a preschool facility.

***Physician's Signature:**	***Date of Exam:**
As required by Rules 5101:2-12-37 and 5101-2-13-37, the child must be examined within twelve months prior to admission.	
Physician's Name:	Phone #:
Address:	
City/State/Zip:	