Student Enrollment Center
115 S. Ludlow St., Dayton, OH 45402
Telephone (937) 542-5555 Fax (937)542-3202

DAYTON PUBLIC SCHOOLS PRESCHOOL MEDICAL FORM

Child's Name: _____ **Date of Birth:** _____

School: _____

Program*: _____
*Preschool programs include: ECE, ECIP and Montessori

EXAM RESULTS:

	Normal	Abnormal	Not Examined
General Appearance			
Posture, Gait			
Behavior			
Skin			
Hair			
Eyes: External			
Eyes: Optic Fundi			
Ears: External & Canals			
Ears: Tympanic Membranes			
Nose, Mouth, & Pharynx			
Teeth			
Heart			
Lungs			
Abdomen (include hernias)			
Genitalia			
Bones, Joints, Muscles			
Neurological			

***Please summarize abnormal findings including chronic physical problems, hospitalizations, or diseases. List treatment plan, services (therapy, medication, referrals):**

_____

_____

_____

***List Food Allergies, Restrictions or Modified Diets:**

_____

***List all Allergies/Treatment (include drug allergies):**

_____

IMMUNIZATION RECORD:
***Exempt from Immunizations:**
Medical/health concern: ❑Yes ❑No
Rationale: _____

Vaccine	Date (month/day/year)				
DPT					
Polio					
MMR					
Hepatitis A					
Hepatitis B					
Varicella					
HIB					
Pneumococcal					
Influenza (Flu)					
Other					

***Additional forms may be required to address health concerns (e.g. medication, treatments, diet)**

REQUIRED Screening:

Height: _____ **Weight:** _____

Blood Pressure_____/_____

Vision:
Stereopsis (Random Dot E) - Pass or Fail, Not tested

Distance Acuity:
Right eye___/___ **Left eye**____/___

Hearing: **PASS** **Rt ear** **Lt ear** **Both ears**
FAIL **Rt ear** **Lt ear** **Both ears**

Laboratory Test	Date	Result
Lead Level*		
Hematocrit*		
Urine dipstick**		
Sickle Cell**		
TB Test**		

*Lab test only **required upon entry** into preschool program.
****Optional** Lab test.

Based upon the medical history and physical condition at the time of this examination, he/she is free from communicable diseases including Tuberculosis; and has received immunizations required by statute for admission to school under Section 3313.671 of the Revised Code, or has had the immunizations required by the State Department of Health for infants and toddlers. In addition the child is in suitable condition for enrollment in a day care center.

_____
DATE OF EXAM*
*Physical exam must have been done in the last 13 months and must be updated yearly for preschool.

_____
Health Care Provider's Signature

Please Validate with Stamp
(Clinic name, address, phone)

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