

Release: I give permission for my physician's office to fax/send this completed form to

Wilmington City Schools
Attn: Preschool Pupil Services
341 S Nelson Ave
Wilmington, OH 45177
Fax: (937) 382-1645

Signature of Parent or legal guardian: _____ Date: _____
 Child's name: _____ Date of Birth: _____
 Parent's name: _____ Child's Age: _____
 Address: _____ Date of Exam: _____

Birth History

Was your child born early, late, or on time? _____
 Birth weight? _____
 Medications used during pregnancy? _____

Medical History

- > Are there any medication or food allergies? _____ If so, please list: _____

- > List any medical problems or diseases your child has/had: _____

- > List any surgeries, hospitalizations, serious injuries, or broken bones: _____

- > Please list any medical problems that run in the immediate family: _____

- > List any problem behaviors your child has exhibited in the past year: _____

Physical Exam:

**Indicates critical areas required by State law.*

Height* _____
 Weight* _____
 Blood Pressure _____
 Hematocrit* _____
 Lead* _____
 Hearing*: Right - Pass/Fail
 Left - Pass/Fail
 Vision*: Right - Pass/Fail
 Left - Pass/Fail

Concerns:

Concerns/Recommendations:

Head _____
 Eyes _____
 Ears _____
 Nose _____
 Throat _____
 Neurological _____
 Neck/Thyroid _____
 Heart _____
 Development _____

Abdomen _____
 Genitalia _____
 Extremities _____
 Spine/Neck _____
 Dental _____
 Skin _____
 Speech _____
 Lungs _____

Immunization Record*:

Please indicate month/date/year of each immunization

DTP 1 _____ 2 _____ 3 _____ 4 _____ 5** _____

Polio 1 _____ 2 _____ 3 _____ 4** _____

MMR 1 _____

HIB 1 _____

***the 5th DTP and 4th Polio should be administered just prior to preschool or school entrance*

- Student has had the immunizations required by section 3313.671 of the Ohio Revised Code for the admission to school, or has had the immunizations required by the Ohio Department of Health for infants and toddlers, ***OR***
- is to be exempted from these requirements for medical or religious reasons.

____ Student is free from apparent communicable disease and is in suitable condition to attend a preschool program based upon his/her medical history and physical condition at the time of this examination.

 Physician's Signature

 Date

 Physician's Name (Please Print)

Address: _____

Phone: _____

Wilmington City Schools

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