

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

**Holmes Elementary**  
Attn: Preschool  
1350 W Truesdell St  
Wilmington, OH 45177  
Fax: (937) 382-2881

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: \_\_\_\_\_

**Holmes Elementary**  
 Attn: Preschool  
 1350 W Truesdell St  
 Wilmington, OH 45177  
 Phone: (937) 382-2750  
 Fax: (937) 382-2881