

MADISON LOCAL SCHOOL DISTRICT

Madison Elementary School

Phone 513-420-4755

Fax 513-420-4915

Child Medical Statement

Child's Name _____

Date of Birth _____ Height _____ Weight _____

Limitations or health condition (including allergies, medications, dietary restrictions):

Immunizations: (please check one and attach immunization record)

Complete for age Yes No

In Process Yes No

Exempt from Immunizations: (please check one)

Religious conviction Yes No

Health concern Yes No

Other: _____

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

Signature: _____

Physician Physician's Assistant or Advanced Practice Nurse

Address _____

Phone: _____ Date of Exam _____

Required for children enrolled in Early Childhood Education Grant Program or Preschool Special Education Program			Reason not completed	
Assessments/ Screenings	Completed Please check one	Date completed	Examples: religious conviction, insurance Coverage, other	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			