LEARNING STEPS PRESCHOOL

955 Liberty Dr., Lancaster, Ohio 43130 PH: 740-653-3193 FAX: 740-653-4053

Child Medical Statement: **To be completed by physician. **Exam must be within the past 12 months**

Child's Name:_____(first, Middle, last) DOB:_____ Date of exam:_____

I authorize my physician _____ to release the completed medical statement to Learning Steps Preschool.
Please fax or email to: 740-653-4053 Attn: Janet Adcock or jadcock@fairfieldesc.org.

_____(Parent signature & date)

Height ____ Weight_____ Blood pressure _____ Allergies(food/drug)& treatment for allergies: _____
History:(diseases, hospitalizations or surgeries) _____

	Normal	Abnormal		Normal	Abnormal
General Apperance			Glands (Lymphatic/Thyroid)		
Posture, Gait			Nose, Mouth, Pharnyx		
Speech			Teeth, Gums		
Head			Heart		
Skin			Lungs		
Eyes			Abdomen		
*symmetrical light reflex			Genitalia		
*external aspects			Bones, Joints, Muscles		
Development			Extremities		
Ears			Muscular Coordination		
Social/Emotional			Neurological (gross, fine, sensory, motor)		

Assessments/Screening	Completed (please circle one)	Date	Assessments/Screening	Completed (Please circle one)	Date
Lead	Yes No		Vison screen	Yes No	
Hemoglobin	Yes No		Hearing screen	Yes No	

Medications: _____
Limitations or health conditions (including food supplements/ modified diets, activity restrictions, health services needed at school): _____

Immunization record (Required by Section 3313.671 of Revised Code and for attendance in preschool program) Please attach a copy *Exempt from immunizations: __ Religious conviction __ Health concern __ Other
Immunizations are complete for age: yes or no Immunizations are not complete for age but are in process: yes or no

I have examined this child and found he/she is in suitable condition for participation in group care.

_____

Signature Physician/Physician's Assistant/Advanced Practice Nurse Printed Name

_____ _____

Address Telephone Fax