

**LIBERTY CHRISTIAN ACADEMY PRESCHOOL STUDENT MEDICAL STATEMENT**

Phone: 740-964-2211      fax: 740-964-2300

Student's Name (print or type)	Date of Birth
Parent(s) Name (print or type)	Date of Exam

**A. This is to certify that I have examined this child and have found that:**

1. This child has had the immunizations required by Section 3313.671 of the Revised Code for admission to school, or has had the immunizations required by the state Department of Health for infants and toddlers, or is to be exempted from these requirements for medical reasons.

**Immunization Record:                      Enter month/day/year of each immunization.**

Required immunizations (month/day/year)					
Vaccine	Dose # 1	Dose # 2	Dose # 3	Dose # 4	Dose # 5
DTP					
OPV					XXXXXXXXXX
HIB					XXXXXXXXXX
MMR			XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX
HepB				XXXXXXXXXX	XXXXXXXXXX
Varicella			XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX

2. Based upon medical history and physical condition at the time of this examination, this child is free from apparent communicable disease and is in suitable condition for participation in group care.

Physician's Name (please print)	Phone #
Street Address	
City, State, Zip Code	
Physician's Signature	Date signed

List all allergies and any special precautions or treatment indicated for these allergies: \_\_\_\_\_

List any medications, food supplements, modifications to diet or fluoride supplements currently being administered to your child and the reason: \_\_\_\_\_

List any diseases your child has had during childhood: \_\_\_\_\_

List chronic physical problems and hospitalization history: \_\_\_\_\_