

# PRESCHOOL STUDENT MEDICAL STATEMENT

## LIBERTY CHRISTIAN ACADEMY

10447 Refugee Road, Pataskala, Ohio 43062

Phone 740-964-2211

Fax 740-964-2311

### COMPLETED BY THE PARENT:

Student's Name (please print)	Date of Birth	Parent's Name (please print)
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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: \_\_\_\_\_

\_\_\_\_\_

Name of Dentist \_\_\_\_\_ Phone Number \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

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### COMPLETED BY THE PHYSICIAN:

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 or religious reasons; or good cause (separate form required for exemption).
2. **An immunization record is attached.**
3. 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 of Exam