

*Avon Lake City Schools*  
LEAPS PRESCHOOL PROGRAM  
**STUDENT MEDICAL STATEMENT**

*This form is to be completed by your child's medical care provider.*

Child's Name: _____	Date of Birth: _____	Age: ____	<input type="checkbox"/> Male <input type="checkbox"/> Female
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**OBJECTIVE DATA**

Height: _____	Weight: _____	BP: _____
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**IMMUNIZATION RECORD**

TYPE	DATE (MONTH/DAY/YEAR)				
<b>DTaP</b>					5th dose required if 4 <sup>th</sup> dose given before age 4.
<b>DT/Td</b>					
<b>Polio</b>				4th dose required if 3 <sup>rd</sup> dose given before age 4.	
<b>MMR</b>				2 <sup>nd</sup> dose required for K 2 <sup>nd</sup> dose required for Gr. 7-12	
<b>Hepatitis B</b>					
<b>Varicella</b>				If the child has had the chicken pox, a note will be required for his/her file.	
<b>HIB</b> (prior to age 5)					
<b>TB Test</b>					
<b>Rotavirus</b>					
<b>Other</b>					

**SCREENING TESTS**

VISION / DATE: _____	HEARING / DATE: _____
Distance Acuity    ___ Right    ___ Left Muscle Balance    ___ Pass    ___ Fail    ___ Not done Farsightedness    ___ Pass    ___ Fail    ___ Not done Color                ___ Pass    ___ Fail    ___ Not done ___ Wears Glasses                ___ Tested with glasses ___ Referral Made to: _____ Specify Tests/Equipment: _____	Pure tone testing: Right Ear            ___ Pass    ___ Fail    ___ Not done Left Ear             ___ Pass    ___ Fail    ___ Not done ___ Wears hearing aid            ___ Tested with hearing aid ___ Referral Made to: _____ Other tests (specify): _____

**SPEECH ASSESSMENT**

**DATE:** \_\_\_\_\_

___ No discernible speech problems ___ Possible problems with:    ___ Articulation    ___ Rhythm    ___ Voice    ___ Language ___ Speech Evaluation is recommended
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**LABORATORY TESTS**

\_\_\_\_\_ Hemaglobin/Hematocrit    \_\_\_\_\_ Urine Protein    \_\_\_\_\_ Urine Blood    \_\_\_\_\_ Urine Glucose    \_\_\_\_\_ Lead  
\_\_\_\_\_ Other

**PHYSICAL EXAMINATION**

**DATE OF EXAMINATION:** \_\_\_\_\_

- Examination results are within normal limits.
- Examination results are NOT within normal limits. Explain:

Does this child have any physical, developmental or behavioral problems?  No     Yes, please explain:

Suggested special programs, placement or attention that the school can provide?

**ACTIVITIES AND LIMITATIONS**

Can the child participate fully in the following activities:

- Yes     No    Classroom and academic activities
- Yes     No    Competitive Athletics

- Yes     No    Physical Education Class
- Yes     No    Contact & Collision sports

Specify any limitations:

**MEDICAL TREATMENT**

- Child is NOT on any medications
- Child takes the following medications for the following conditions:

*This certifies that I have examined this child and*

(1)  *he/she has had the immunizations required by Section 3313.671 of the Ohio Revised Code for admission to school, or has had the immunizations required by the Ohio Department of Health for infants and toddlers*

**OR**

*he/she is exempted from these requirements for medical or religious reasons.*

(2)  *he/she is free from communicable diseases and is in suitable condition to attend a preschool program, based on his/her medical history and physical condition at the time of this examination.*

Examiner's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Examiner's Name (please print): \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_