MADISON LOCAL SCHOOLS

Fax 513-420-4990

Child Medical Statement

Child's Name _____ Date of Birth _____

Height _____ Weight _____

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

Immunizations: Please check one: (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	_____Yes _____No			
Hearing	_____Yes _____No			
Dental	_____Yes _____No			
Lead	_____Yes _____No			
Hemoglobin	_____Yes _____No			