2080 Citygate Drive • Columbus, OH 43219
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www.escofcentralohio.org

Student's Medical Statement

Child's Name:		Sex:		Birth Date:	
Address:					
Phone:					
Name of Parent/Guardian(s):					
Insurance Information (Optional):					
Date of Exam:				Expires:	

Immunization Record:

Enter month/day/year of each immunization

Vaccine	1	2	3	4	5
DTP (4 required)					
HIB (1-4 required)					
Polio (OPV/IPV) (3 required)					
Hepatitis B (3 required)					
Varicella (*Chickenpox*) (not required)					
MMR (1 required)					

Medical History		
Allergies:	Symptoms:	Treatment:
Diet Restrictions:		
Current Medications (dosage and frequency):		
Known Health Conditions: (if seizures, describe type and frequency), sickle cell, etc.: List precautions or limitations required for school		
Currently Under Treatment For:		Referred To:

(see next page)

Please record the results of the following lab tests. Explain reason if not given:

LAB Tests	Hgb/Hct:		Date:		Iron Supplement?	
PPD:			Date:			
Lead Screen Results:			Date:			
Sickle Cell Screen Results:				Date:		

Physical Examination		Date:				
Height:		In.	Weight:		Lbs.	
Visual Acuity:	R		L		OU	
Hearing	R		db	L		db

Please Check

- ☐ Physical exam completed and no abnormalities found; or
- ☐ Abnormalities found on physical exam are (explain):
- ☐ Referral made to (explain):

Based upon the medical history and physical condition at the time of this examination, this child is free from apparent communicable diseases and is in suitable condition to receive child care. This child 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 State Department of Health for infants and toddlers, or is to be exempt from the requirements for medical reasons. Please note exemptions: ______________________________

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Physician's Signature: ______________________ Date: __________

Address: ______________________________

Telephone: ______________________________