Assumption Academy

Preschool Physical Form

(This form must be completed and signed by your Physician)

Name:_____ **Birth Date:**_____
Last First

Address:_____**Phone #:**_____
Street City Zip Code

Parent(s) or Guardian (s):_____**Mother**_____**Father**_____**Other**_____
First Name Last Name

EXAMINATION

For children three years or older at the time of school admission the examination shall occur within the twelve months prior to admission (O.R.C. 3301-37-05)

Date:_____ **B.P.:**_____
Height:_____ **Weight:**_____
Eyes:_____ **Vision: R. 20/**_____ **L. 20/**_____
Ears:_____ **Hearing Test - Type:**_____ **R.**_____ **L.**_____
Nose:_____ **Throat:**_____
Mouth:_____ **Teeth:**_____
Is dental work indicated? Yes No **If so, are plans being made? Yes No**
Posture:_____ **General Condition:**_____
Skin:_____ **Orthopedic:**_____
Neck:_____ **Nervous System:**_____
Heart:_____ **Lungs:**_____
Abdomen:_____ **Hernia:**_____
Genitalia:_____ **Urinalysis:**_____
Allergies:_____
Remarks/Recommendations:_____

IMMUNIZATIONS (Please include month/day/year)

DPT: **1st**_____ **2nd**_____ **3rd**_____ **4th**_____ ***5th**_____
Polio Vaccine (OPV/IPV): **1st**_____ **2nd**_____ **3rd**_____ **4th**_____
MMR: **1st** _____ **2nd**_____
If separate: **Measles:**_____ **Mumps:**_____ **Rubella:**_____
Hib (Haemophilus B): **1st**_____ **2nd**_____ **3rd**_____ **4th**_____
Hepatitis B: **1st**_____ **2nd**_____ **3rd**_____
Varicella: **1st**_____ **2nd**_____
Tuberculin Test: **Date:**_____ **Results:**
MCV4 (Meningococcal) **1st**_____ **2nd**_____
Hepatitis A: **1st**_____ **2nd**_____
PCV-Prevnar: **1st**_____ **2nd**_____ **3rd**_____ **4th**_____
Influenza: _____

I certify that the above named child has been examined, the immunization status recorded, and is in suitable condition for participation in group care. I certify that the above named child has been immunized in accordance with the requirements of section 5104.014 of the Ohio Revised Code. (Please note exceptions on the opposite side of this page.)

_____
Physician Signature **Date**

_____
Address **Phone**

_____
Parent/Guardian Signature **Date**

Exceptions to Immunization Requirements pursuant to 5104.014 ORC.

Please include the names of requirement diseases against which the child has not been immunized and whether it is because the immunization is medically contraindicated, not medically appropriate for the child's age, or declined by parent.

_____

_____

_____

_____

_____

_____I have declined to have my child immunized against one or more of the diseases required by 5104.014 of the Ohio Revised code. Please note disease above and sign.

Signature of Parent/Guardian:_____Date:_____