

Child's Medical Statement

Child's Name: _____ Date of Birth _____
 (Please print child's full name)

Date of Exam _____ Height _____ Weight _____

A. 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 reasons.

VACCINE	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5
DtaP, DTP, or DT (Pediatric)					
HIB					
Polio Vaccine					
MMR					
Hepatitis B					
Varicella (chicken pox)					
OTHER					

IMMUNIZATION SCHEDULE PER STATE OF OHIO LAW.

<u>Preschool children need:</u>	<u>Kindergarten children need:</u>	<u>1-8 grade children need:</u>
4 doses of DtaP, DTP, or DT	5 doses of DTaP, DTP, or DT	4 doses of DtaP, DTP or DT
3 or 4 doses of HIB	4 doses of Polio Vaccine	3 or 4 doses of Polio vaccine
3 doses of Polio Vaccine	2 doses of MMR	2 doses of MMR
1 dose of MMR	3 dose of Hepatitis B	3 dose of Hepatitis B
3 doses of Hepatitis B	1 dose of Varicella or written statement claiming history of disease	1 dose of Varicella or written statement claiming history

- 2) 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 to receive child day care.

B. 1) List any handicap, allergy or special health condition of the child: _____

2) Indicate any limitations or modifications of the child's participation in daily child day care activities or any special treatments needed: _____

Name of Physician (please print)	Telephone Number
Street Address	Fax Number
City, State, and Zip Code	Date of Exam
Physician's Signature	Date of Physician's Signature

Montessori School at Holy Rosary
12009 Mayfield Road, Cleveland, Ohio 44106
216-421-0700 (phone) 216-421-2310 (fax)

Students entering kindergarten and fourth grade *must* have an up-to-date hearing & vision screening.

Hearing Screening

Child's Name : _____ D.O.B. _____

Date of Screening: _____

Results of Screening: _____

Referral Recommended: _____

Notes: _____

Licensed professional performing Hearing Screening: _____

Address: _____ Phone: _____

Signature of Professional

Date

Vision Screening

Child's Name : _____ D.O.B. _____

Date of Screening: _____

Results of Screening: _____

Referral Recommended: _____

Notes: _____

Licensed professional performing Vision Screening: _____

Address: _____ Phone: _____

Signature of Professional

Date