HERITAGE CHRISTIAN SCHOOL

2107 6th Street S.W. Canton, Ohio 44706 330.452.8271 Fax: 330.452.0672 www.heritagechristianschool.org

MEDICAL STATEMENT

Child's Last Name First	Birth Date	Age
Address	Zip	Phone
Parent/Guardian	School	

Parental consent for release of his medical statement

I, the legal guardian, authorize the release of this medical statement to Heritage Christian Pre-School.

*SIGNATURE_____________________________ DATE______________________

REQUIRED PHYSICAL ASSESSMENT: WNL YES________ NO________

Please note if any follow up is required: * Lead________________

Height____________________ Blood Pressure____________________

Weight____________________ * Hematocrit or Hemoglobin____________

ALLERGIES – INCLUDE FOOD NKA: Yes_____ No_____ Treatment_______________

____

List any medications, food supplements, modified diets, or fluoride supplements currently being administered to the child.

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* Required by ODE

SCREENINGS:	WNL	FOLLOW UP REQUIRED
Vision (beginning at age 3)		
Hearing (beginning at age 3)		
Speech		

Immunizations: Please include month, day, and year. *Indicates required for public pre-school.

HIB	DPT	Please circle type of polio given:	MMR	PREVNAR	HEP B
#1*______	#1*______	OPV/IPV #1*_______	#1*______	#1 * ______	#1*_______
#2_______	#2*______	OPV/IPV #2*_______	#2 ______	#2 _______	#2*_______
#3_______	#3*______	OPV/IPV #3*_______	VZV	#3 _______	#3*_______
#4_______	#4*______	OPV/IPV #4 _______	#1_______	#4 _______	HEP A
Only one HIB required if given after 15 months of age. Please indicate if 4th HIB is not required	#5_______		#2_______		#1_______
					#2_______

TB last given_______________ Sickle Cell_______________ Other_______________

THIS STATEMENT AFFIRMS THAT THE ABOVE NAMED CHILD IS IN SUITABLE CONDITION FOR ENROLLEMENT IN A PRE-KINDERGARTEN PROGRAM.

PHYSICIAN'S SIGNATURE	DATE
Physician's Name (Please Print)	
Physician's Address	
City, State, Zip	Phone: ( ) -