



SANDUSKY
CENTRAL
CATHOLIC
SCHOOL

Child Medical Statement

Childs' Name _____ Date of Birth _____

Height _____ Weight _____

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

--

Immunizations: Please check one

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 of examining (check one)

☐ Physician, ☐ Physician's Assistant or ☐ Advanced Practice Nurse

Address : _____

Phone: _____ Date of exam _____

Required for children enrolled in an Early Childhood Education Grant Program or Preschool Special Education Program			Reason not completed (Check which applies)	
Assessments/ Screenings	Completed Please check one	Date Completed	Examples: religious conviction, insurance coverage, other	Health professional decision
Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Hearing	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Dental	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Lead	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Hemoglobin	<input type="checkbox"/> Yes <input type="checkbox"/> No			