TRUMBULL COUNTY EDUCATIONAL SERVICE CENTER PRESCHOOL PROGRAM

CHILD MEDICAL STATEMENT

Child's Name		Date of Birth
Date of Exam	Height	Weight

Limitations or Health Conditions *(including allergies, medications, dietary restrictions, physical limitations, other)*

Immunizations	**Please circle one**	
Complete for age	Yes	No
In Process	Yes	No
Exempt from Immunizations	Religious conviction	Health Concern

Please attach a copy of the child's most recent immunization record

This child has been examined and is in suitable condition to participate in the preschool program.	
Signature of examining (circle one) Physician / Physician's Assistant / Advanced Practice Nurse Address : Phone:	Date of Exam

Required Assessment/Screenings for the Early Childhood Education or Preschool Special Education Program

Assessment/ Screening	Completed *Please circle one*		Date completed	Results	Reason not completed *(ex. Religious convictions, insurance, Health professional decision, other)*
Vision	Yes	No			
Hearing	Yes	No			
Dental	Yes	No			
Lead	Yes	No			
Hemoglobin	Yes	No			
BMI	Yes	No			
TB	Yes	No			
Hepatitis B	Yes	No			