Perry Local Schools Preschool Registration

Child's Physician Medical Statement

This document is to be completed by the child's Physician, Physician's Assistant, or Advanced Practice Nurse.

Child's Name: _____

Date of Birth: _____ Height: _____ Weight: _____ Sex: Male____ Female____

Limitations or health conditions including allergies, medications, dietary restrictions, etc.

_____

_____

_____

Immunizations	**Please circle one**	
Complete for age	Yes	No
In Progress	Yes	No
Exempt from Immunizations	Religious Beliefs	Health Concerns

Please attach a copy of the child's most recent immunization record to this document.

* This child has been examined and is in suitable condition to participate in the preschool program.

Signature:_____ Position_____ Date:_____

Name of practice:_____

Address:_____

Phone:_____

Required Screenings for all students attending the Perry Local Schools Preschool Program				
Assessment/Screening	Completed (Please circle one)	Date Completed	Results	Reason Not Completed
Vision	Yes No			
Hearing	Yes No			
Dental	Yes No			
Lead Screening	Yes No			
Hematocrit or Hemoglobin	Yes No			