Rockwern Academy
Discover. Believe. Achieve.

8401 Montgomery Rd.
Cincinnati, OH 45236
Phone: 513-984-3770, ext. 3135, Fax: 513-984-3974(General)

CHILD MEDICAL STATEMENT

This form is **REQUIRED** and must be completed and signed by a physician **ANNUALLY** for **all preschool and kindergarten students under the age of 6 years and new students in 1st – 8th grades.** This form must be on file prior to the first day of school.

Student Name	□ Male □ Female	Age	Date of Birth

This is to certify all of the following:

- I have examined this child and found that he or she is in suitable condition for participation in group care and/or school..
- The child had the age appropriate immunizations recommended by the Ohio Department of Health and is free from apparent communicable disease and is in suitable condition to attend a preschool/school program based on his/her medical history & physical condition at the time of this examination.
- My office has entered the child's immunizations record below or attached a printed record of the immunizations or found that this child should be exempt from immunizations for the following reasons: _____

  _____.

List any limitations or health conditions for this child (including allergies, daily medication, dietary restrictions) _____

_____

_____

Immunizations (enter month, day, and year) *** Required by State**					
Vaccines	**Dose 1**	**Dose 2**	**Dose 3**	**Dose 4**	**Dose 5**
*Diptheria, Tetanus, Pertussis (DTaP)					
*Hepatitis B (Hep B)					
*Haemophilus Influenza type b (HIB) – required for preschool					
*Measles, Mumps, Rubella (MMR)					
*Polio (IPV)					
*Varicella (chicken pox)					
*Tdap (required for 7th grade)					
Pneumococcal Conjugate (PCV)					
TB	Type	Result			
Influenza					
Other					

Recommended Assessments/Screenings:

Vision: □Yes □No Date: _____ Hearing: □Yes □No Date: _____
Dental: □Yes □No Date: _____ Lead: □Yes □No Date: _____
BMI: □Yes □No Date: _____ Other: □Yes □No Date: _____

REQUIRED:

Signature of examining Physician/Physician's Assistant/Advanced Practice Nurse	**Date of Exam**	**Date Form Signed**

Name of Physician/Physician's Assistant Advanced Practice Nurse (Please print.)	Name Stamp (if available)	Telephone Number
Street Address		
City, State & Zip Code		