St. Brendan School
4242 Brendan Lane
North Olmsted, Ohio 44070
Phone: 440.777.8433 / Fax: 440.779.7997

Child's *Preschool* Medical Statement
PHYSICIAN FORM
20 _____ - 20 _____

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This is to certify that I have examined (child's name) ____
on (date) _____________________ and have found that he / she:

1. Has had the immunization required by Section 3313.671 of the Ohio Revised Code for admission to school, or has had the immunizations required by the Ohio Department of Health for infants and toddlers, or is to be exempted from these requirements for medical or religious reasons.

Immunization Record. Enter month / day / year of each immunization.

DPT: 1 _______ 2 _______ 3 _______ 4 _______ *5 ________

POLIO: 1 _______ 2________ 3 _______ 4 _______

MEASLES, MUMPS, RUBELLA (usually combined as MMR): 1 _______ *2 ________

If separate, measles _________, mumps _________, rubella _________
* Usually administered just prior to Preschool or school entrances.

________Hepatitis A 1_______ 2________

________Hepatitis B 1_______ 2 _______ 3 _______

_______ Hib 1 _______ 2 _______ 3 _______ 4 _______ 5 _______

_______Prevnar (PCV) 1 _______ 2 _______ 3 _______ 4 _______

_______ Chicken Pox

_______ Influenza Vaccine

2. Is free from apparent communicable disease and is in suitable condition to attend a Preschool Program, based on his / her medical history and physical condition at the time of this examination.

Physician's Name (Please Print): ____

Physician's Signature: ____

Street Address: ____

City, State, Zip Code:____

Parent's Signature: _____________________________________ Date: __________________________

Child's Birth Date: ____

Revised 08/17
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