

ESC of the Western Reserve Preschool Program

2024-205 School Year

Child Medical Statement

8221 Auburn Road Painesville, Ohio 44077

Office Number: 440.350.2563 ext 1734

Fax Number: 440-490-7009 (attention: Amy Dawson)

Email: Adawson@escwr.org

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

Child's Name: _____ Preschool Program: _____

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
In Progress	Yes	No
Exempt from Immunizations	Religious Conviction	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	
Physician, Physicians Assistant, or Advanced Practice Nurse (circle one)	Date of the Exam
Address:	
Phone:	
Signature of Examiner: _____	

Required Assessment/Screenings for all students attending the ESC of the Western Reserve Preschool Program					
Assessment/Screening	Completed (please circle one)		Date Completed	Results	Reasons Not Completed
Vision	Yes	No			
Hearing	Yes	No			
Dental	Yes	No			
Lead Screening	Yes	No			
Hematocrit or Hemoglobin	Yes	No			