PRESCHOOL

Vinton County Local School District
307 West High Street
McArthur, Ohio 45651
Phone 740-596-5218 - Fax 740-596-3142

Child Medical Statement

Childs' Name______________________________ Date of Birth______________

Height ____________ Weight___________

Limitations or health condition (including allergies, medications, dietary restrictions)

Immunizations	Please circle one	
Complete for age	Yes	No
In Process	Yes	No

Exempt from Immunizations	Please circle one	
Religious conviction	Yes	No
Health concern	Yes	No
Other:		

This child has been examined and is in suitable condition to participate in group care

Signature of examining Physician/ Physicians Assistant or Advanced Practice Nurse (circle one) Address : Phone:	Date of exam

Required for children enrolled in an Early Childhood Education Grant Program or Preschool Special Education Program				Reason not completed (Check which applies)	
Assessments/Screenings	Completed Please circle one		Date Completed	Health professional decision	Examples: religious conviction, insurance coverage, other
Vision	Yes	No			
Hearing	Yes	No			
Dental	Yes	No			
Lead	Yes	No			
Hemoglobin	Yes	No			

Vinton County Local School District
307 West High Street
McArthur, Ohio 45651
Phone: 740-596-5218 Fax: 740-596-3142

ECU 3301-13

DENTAL FORM

Name of Child:	Male / Female
Date of Birth:	
Parent(s)/Guardian Name:	

1. Is the child now receiving any of the following? If "yes", include length of time receiving fluoride.

Topical fluoride application	______No	______Unknown	______Yes
Fluoridated water	______No	______Unknown	______Yes
Fluoride supplement diet	______No	______Unknown	______Yes

2. Does the child have any of the following? If "yes", provide details on the emergency medical form.

Allergies	______Yes	______No
Asthma	______Yes	______No
Bleeding	______Yes	______No
Diabetes	______Yes	______No
Epilepsy	______Yes	______No
Heat/Vascular disease	______Yes	______No
Liver disease	______Yes	______No
Rheumatic fever	______Yes	______No
Sickle cell disease	______Yes	______No
Other (Please list)	______________________________	

3. Does the child have any trouble with teeth, gums, or mouth? __________Yes ______No
   If so, what kind? ____

4. Child has previously seen a dentist? ______Yes ________No

5. Child is under a physician's care? ______Yes ________No

6. Child is receiving medication? ______Yes ________No

7. PLEASE PROVIDE A WRITTEN SUMMARY OF SERVICES REQUIRED (on back of form):
   - For the relief of pain or infection
   - Restoration and/or pulp therapy of decayed primary and permanent teeth
   - Extraction of non-restorable teeth
   - Dental prophylaxis and instruction in self-care oral hygiene procedures.

Dentist or Physician Signature	Signature Date:
Dentist/Physician Name Printed	
Complete Address	
Phone	

This is a SAMPLE FORM provided by the Ohio Department of Education that may be used to comply with the Head Start Performance Standards regarding dental examination and data (45 CFR 1304.3-3,4,5). The annual dental exam by a dentist is an oral diagnostic procedure which should include radiographs (x-rays) only if the dentist determines that they are absolutely necessary. This should be completed within 90 days of the child's entrance into the program. Developmental dental history should be part of health screening completed within 45 days of entrance.

Rev. 5/10