LEGACY
CHRISTIAN ACADEMY

1101 Wesley Avenue
Xenia, Ohio 45385
legacyknights.org
Clinic: 937-352-1655 f: 937-352-1641

Pre-K STUDENT HEALTH RECORD

Student Name:		Date:
Birthdate: ____/____/____	Gender:	Grade Enrolling:
Previous School, City and State		
Parent(s)/Guardian:	Email Address:	
Home Address:	City:	Zip:
Home Phone:	Cell #:	Work #:

RECORD OF IMMUNIZATIONS

Required Immunizations Pre-K

Health Service's requests a copy of the immunization record from either a physician's office or county health department to accompany this health record. Day, month and year of each dose received is required. This may be faxed directly to the clinic.

Prior to Kindergarten – *"Five year old" shots need to be given which include 5th DTaP, 4th or 5th Polio, 2nd MMR and 2nd Varicella.* ****

Students must have a current physical in the last 12 months, current immunizations, and a physician signature (no print/ stamp) before the first day of preschool. Students will not be able to come to preschool until these qualifications are met.*

********** Physician Office**********

Did examination reveal any abnormalities in the following areas?

	YES	NO		YES	NO		YES	NO
General Appearance			Neuromuscular			Skeletal System		
Abdomen			Skin			Lymph Nodes		
Eyes			Ears			Noses/Throat		
Lungs			Genitalia			Teeth/Gums		
Tongue and Palate			Heart BP:			Emotional		

DESCRIBE FULLY ANY ABNORMALITIES:		
Lead Test if R.E.P. is High:	Sickle Cell Anemia:	Urinalysis:
Hearing:	Speech:	Vision:

Please list any allergies:	Reaction:	EpiPen Y	N

Indicate your child's past/present disease(s):

____Heart Disease	____Rheumatic Fever	____Diabetes	____Tuberculosis
____Epilepsy, Seizures	____Frequent Skin Infections	____Kidney Disease	____Meningitis
____Chicken Pox	____German Measles	____Sickle Cell Disease	____Mumps
____Eczema	____Old Fashion Measles	____Encephalitis	____Hepatitis B
____AIDS/HIV	____Asthma or Wheezing	____Other	____Stool Soiling

Is your child on any medication? ____Yes ____No	Please indicate the medication and reason it is being taken:
Are there medications given "**as needed**" ____Yes ____No	Please indicate reason medication is being taken:
Does student have a physical/medical handicap? __Yes __No Explain:	Has student ever had a convulsion? ___Yes ___No Explain:
Describe student's eating habits including modified diets; food supplements or fluoride supplements if any:	
Does student have trouble with bladder control? __Yes __No	Is student a bed-wetter? ___Yes ___No
Chronic diarrhea or constipation? ___Yes ___No	
Mental illness/Neurological condition ___Yes ___No Explain:	
Would you say student is ___very active, __average, ___quiet	Other health problems the school nurse should know about:
Nervous twitching or tics? ___Yes ___No	
Physical Activity: Limitations? ___Yes ___No Explain:	

The above named child has been examined, the immunization status recorded, and the child is suitable for group care.

Parent Signature _____Date _____

A physical exam is required every 12 months

The above child named child has been immunized in accordance with the requirements of section 5104.014 of the Ohio Revised Code (please note any exceptions below.

Preschool Physical Exam Date:_____ **Physician/CNP Signature(no print/stamp)** _____

Physician's Address