LEGACY CHRISTIAN ACADEMY

1101 Wesley Ave
Xenia, OH 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.*

TYPE	DATE (MO/DAY/YR)				
DTaP, DPT, or DT					
Polio					
Hepatitis B					
Hepatitis A					
MMR					
Varicella					
Pneumococcal					
HIB					
Rotavirus					
Influenza					

********** 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:	

Parent Signature _____ Date _____

A physical exam is required every 13 months

Preschool Physical Exam Date:_____ **Physician/CNP Signature**_____

Physician's Address