Lebanon City Schools
Preschool and Kindergarten Physical

Name of Student: _____ **Date of Birth:** ____/____/_____ **Address:** _____

IMMUNIZATIONS
Full Date (Month/Day/Year) Required By Ohio Law
PRE-SCHOOL
(4 DPT, 3 IPV, 1 MMR, 3 HEPATITIS B, 1 VARICELLA, 3-4 HIB)
SCHOOL AGE
(5 DPT, 4 IPV, 2MMR, 3 HEPATITIS B, 2 VARICELLA)

DATE	M/D/Y	M/D/Y	M/D/Y	M/D/Y	M/D/Y
DPT					
TD					
Polio					
Measles					
Mumps					
Rubella					
HEP B					
TB					
Varicella					
HIB					

DENTAL REPORT

The following services have been performed:
□ Fluoride Treatment
□ Oral Prophylaxis
□ Radiographs
□ Restorations

The following statements are applicable:
□ All necessary services have been performed
□ No restorative services are required at this time
□ Further treatment is indicated
□ Future appointments have been arranged

COMMENTS:

Signature of Dentist Date

PHYSICIAN'S REPORT

REVISED APRIL 2021

CHECK ONE:

_____ Entirely within normal limits

_____ List any abnormalities, health problems and/or medications regarding this student:

VISION SCREENING

R_____ L_____

HEARING SCREENING

R_____ L_____

Please explain if this student cannot carry out a full program of school activities:

_____

_____

_____

REQUIRED FOR PRESCHOOL:

_____ Height
_____ Weight
_____ Hematocrit
_____ Hemoglobin
_____ Lead Screen

DISCLAIMER TO PARENTS/GUARDIANS: The information requested on this form will be of help to the school in determining the health status of your child and in assisting the student to receive maximum benefits from his/her educational opportunity. This health information will be shared with other school personnel, unless you indicate otherwise.

PAST MEDICAL HISTORY

	YES	NO
Activity Restriction		
ADD/ADHD		
Allergies		
Asthma		
Birth/Congenital Malformation		
Bleeding Disorder		
Bowel/Bladder Concern		
Chickenpox		
Cystic Fibrosis		
Diabetes		
Earaches		
Emotional Concerns		
Hearing Problems		
Heart Condition		
Hospitalizations		
Infectious Hepatitis		
Injuries		
Kidney Disease		
Seizures		
Skin Condition		
Surgery		
Tics/Nervous Twitches		
Toileting Concern		
Other Illnesses		

COMMENTS:

_____
_____
_____
_____
_____
_____
_____
_____

Signature of Physician Date