MSMV
MONTESSORI SCHOOL OF THE MAHONING VALLEY

CHILD MEDICAL STATEMENT AND REQUIRED IMMUNIZATION RECORD

Child's Name: _____ **Date of Birth:** _____

Name of Physician:	**Telephone Number:**
Street Address:	
City, State, Zip Code	
Signature of Examining Physician:	**Date of Examination:**

☐ **The above named child has been examined and he/she is free from apparent communicable disease and is in suitable condition to attend a preschool or school program based on his/her medical history and physical condition at the time of this examination.**

Measurements

Height: _____

Weight: _____

BMI: _____

Does this child have any developmental disorders of which you are aware?

☐ **YES** ☐ **NO**

If yes, explain: _____

_____

Notes/Additional Comments (Allergies, recommendations, etc.):

TO BE COMPLETED BY PHYSICIAN/PHYSICIAN'S ASSISTANT/ADVANCED PRACTICE NURSE/CERTIFIED NURSE PRACTITIONER

PLEASE CHECK ALL THAT APPLY:

Vaccination	Immunized	In Process of Immunization	Medically Contraindicated/ Not Age Appropriate
DtaP/DT(Diptheria, Tetanus, Pertussis)	☐	☐	☐
Polio	☐	☐	☐
MMR (Measles, Mumps, Rubella)	☐	☐	☐
Hib (Haemophilus Influenzae Type b)	☐	☐	☐
Hepatitis A	☐	☐	☐
Hepatitis B	☐	☐	☐
Varicella (Chicken Pox)	☐	☐	☐
PCV (Pneumococcal conjugate vaccine)	☐	☐	☐
Influenza (Flu)	☐	☐	☐
Meningococcal (MCV4)	☐	☐	☐

☐ **I have declined to have my child immunized against one or more of the diseases required by 5104.014 of the Ohio Revised Code. *Please initial beside each vaccine being declined, and sign below.***

Parent /Guardian Signature: **Date of Signature:**

PLEASE ATTACH A COPY OF THE CHILD'S IMMUNIZATION RECORD WITH DATES AND DOSES OF ALL IMMUNIZATIONS*