Child Medical Statement

for St. Vincent de Paul Preschool

206 East Chestnut Street Mount Vernon, Ohio 43050
Phone (740) 393-3611 Fax (740) 393-0236

This form must be completed by a Physician(MD/DO), Physician Assistant(PA) or Advanced Practice Nurse(APRN).

Child's Name _____

Child's Date of Birth _____ **Height** _____ **Weight** _____

List all restrictions, limitations, health conditions, allergies, medications & dietary restrictions:

Immunizations:	**If exempt from immunizations, please note the reason:**
Complete for age ◯**Yes** ◯**No**	◯ **Religious Conviction**
If not, are they in process? ◯**Yes** ◯**No**	◯ **Health Concerns**
Please Attach Immunization Record	**Other** _____

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

Signature of Medical Professional _____

Printed Name of Medical Professional _____

Check the appropriate circle regarding the examining medical professional:

◯ **MD/DO** ◯ **PA** ◯ **APRN**

Clinic/Hospital Name _____

Provider Address _____

Provider Phone Number _____

Date of Exam _____