Lexington Local Schools

Lexington Preschool
890 West 4th Street
Mansfield, Ohio 44903
419-884-1111 ext. 6500

Name: _____ DOB: _____

Date of Physical: _____ Age: _____ Weight:: _____ Height: _____

PHYSICAL EXAM TO BE FILLED IN & SIGNED BY PHYSICIAN

___ Essentially Normal
___ Abnormalities as follows:

Posture/Gait: _____
Skin: _____
Eyes/Vision: _____
Throat (tonsils): _____
Ears/Hearing: _____
Mouth (teeth) _____
Speech/Language: _____
Treatments of Allergies: _____

Lungs: _____
Abdomen: _____
Genitalia: _____
Emotional: _____
Neurological: _____
Heart: _____
ALLERGIES: _____

LABORATORY TESTS (* = required for preschool)

*HgB_____ *Hct_____ *Lead_____ Urinalysis (optional) _____

Signature required here if physician determines the above laboratory tests are not necessary for this child. Physician's signature: _____

May this student carry a full physical education program? _____
Please explain any restrictions: _____
What medication, if any, is the child taking? _____

PHYSICIAN'S ASSESSMENT

Problem	Recommendation for School Management
1. _____	_____
2. _____	_____

Physician's Name: _____ Office Phone: _____

Physician's Signature: _____ Date: _____

*****SEE OTHER SIDE FOR IMMUNIZATION REQUIREMENTS*****

Immunization Requirements for Preschool

Effective 2016-2017 School Year

Vaccine	Requirements
DtaP/DT	4 doses
Hib	3 or 4 doses given before 15 months or 1 dose if after 15 months
Hep A	1 dose after first birthday
Hep B	3 doses
Influenza	1 dose yearly age 6 months through age 6
MMR	1 dose after first birthday
Pneumococcal	2 or 4 doses depending on age at first dose
Polio	3 doses
Varivax	1 dose

Immunization Requirements for Kindergarten

Effective 2016-2017 School Year

DtaP/DT	4 doses including a booster after 4th birthday
MMR	2 doses after first birthday
Hep B	3 doses
Polio	3 doses including a booster after 4th birthday
Varivax	2 doses or history of chicken pox disease

Immunization Requirements for Grade 7

Effective 2016-2017 School Year

DtaP/DT	Booster
Meningitis	1 dose

IMMUNIZATION RECORD

DtaP/DT _____ _____ _____ _____ _____

Hib _____ _____ _____ _____ _____

Hep A _____ _____ _____ _____ _____

Hep B _____ _____ _____ _____ _____

Influenza _____ _____ _____ _____ _____

MMR _____ _____ _____ _____ _____

Pneumococcal _____ _____ _____ _____ _____

Polio _____ _____ _____ _____ _____

Varivax _____ _____ _____ _____ _____

Other: _____ _____ _____ Date: _____

TB: Date: _____ Test: _____ Result: _____

Updated 02/25/2016