Akron Children's Hospital
SCHOOL HEALTH SERVICES

Healthcare Provider Report

Early Childhood Education/Preschool Special Education Program

School Year:_____ **Grade:**_____ Date of Exam:

Name:_____ **Male** ____ **Female** ____ **Date of Birth:** _____

Height: _____(_____%ile) **Weight:** _____(_____%ile) **B.P.:**_____ **Pulse:** _____

Immunizations	Please Circle One		Exempt from Immunizations	Please Circle One	
Complete for Age	Yes	No	Health Concern	Yes	No
In Process	Yes	No	Religious/Philosophical	Yes	No

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

Assessments/Screenings	Completed Please Circle One	Date Completed (please enter if completed previously)	Reason Not Completed Please list reason
Vision	Yes No		
Hearing	Yes No		
Dental	Yes No		
Lead	Yes No		
Hemoglobin	Yes No		

Special Health Conditions (allergies, medications, chronic conditions, etc)

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

_____
Healthcare Provider Signature

_____
Healthcare Provider Name (please print)

_____
Healthcare Provider address

_____
Healthcare Provider phone