# STUDENT HEALTH RECORD/RECORD OF IMMUNIZATION/MEDICAL STATEMENT
## Preschool, Kindergarten and New Students

**St. Charles Borromeo School*4600 Ackerman Blvd * Kettering, OH 45429 * 937-434-4933 *937- 434-6692 (fax)**

## SECTION I - HEALTH RECORD – Completed by Parent/Guardian (For ALL Preschool, Kindergarten & New Students)

**CHILD'S NAME**_____
***(Please print)*** ***Last*** ***First*** ***Middle Initial*** ***Date of Birth***
Child's Nickname:_____ Grade: _____ Gender: ☐ Male ☐ Female

Name of Parent(s)/Guardian: _____

**INSTRUCTIONS – parent, please answer 1-6 below and sign.**

1. Please review the conditions/concerns below and circle YES or NO as it applies to your child:

| | | | | | |
|---|---|---|---|---|---|
| **Asthma/wheezing/reactive airway** | YES | NO | **Ear/hearing problems** | YES | NO |
| **Seizure disorder** | YES | NO | **Wears a hearing aid** | YES | NO |
| **Diabetes** | YES | NO | **Frequent ear infections** | YES | NO |
| **Heart disease** | YES | NO | **PE Ear Tubes/When inserted?** | YES | NO |
| **Down Syndrome** | YES | NO | **Difficulty producing sounds** | YES | NO |
| **Cerebral Palsy** | YES | NO | **Enrolled in speech therapy** | YES | NO |
| **Cancer or history of cancer** | YES | NO | **Difficulty being understood by others** | YES | NO |
| **Has/has had Chicken Pox or Tuberculosis** | YES | NO | **Difficulty hearing/understanding directions** | YES | NO |
| **ADHD/ADD** | YES | NO | **Dental concerns** | YES | NO |
| **Fears/anxiety** | YES | NO | **Frequent bathroom use** | YES | NO |
| **Mental Health Disorder** | YES | NO | **Physical limitations or disability** | YES | NO |
| **Eye/vision problems** | YES | NO | **Serious illness, injury, or surgery** | YES | NO |
| **Wears glasses/contacts** | YES | NO | **Currently taking medications/supplements** | YES | NO |
| **Tires easily** | YES | NO | **Currently under a doctor's care?** | YES | NO |
| **Born premature? How many weeks?** | YES | NO | **Other (list):** | YES | NO |

If you circled **YES** above, please explain:
_____
_____

2. Does your child have any allergies to medications, foods, insects or inhalants? ☐ YES ☐ NO
If yes, list and describe reaction:_____

3. Will your child require medication(s) at school? ☐ YES ☐ NO
If yes, describe and complete Request for Dispensing Prescription/Nonprescription Medication at School form found on Option C –File Library: _____

4. Would you say your child is: ☐ Very active ☐ Average ☐ Quiet

5. Behavioral Concerns (check all that apply):
☐ Hyperactive ☐ Distracted ☐ Short Attention Span ☐ Withdrawn ☐ Aggression

6. Please state any other health problems your child may have that would be important for the school to know: _____

7. Date of last physical exam: _____Date of last dental exam: _____Date of last eye exam: _____

**Signature of Parent _____Date _____**

## SECTION II - RECORD OF IMMUNIZATION / MEDICAL STATEMENT– Completed by Health Care Provider

***PRESCHOOL - Section II MUST be completed**
***TK/KINDERGARTEN - Provide the school with your child's vaccination record *OR* complete Section II**
***1st-8th Grade - DO NOT NEED TO COMPLETE SECTION II. Immunization record(s) should be transferred from previous school**

**CHILD'S NAME**_____
***(Please print)*** ***Last*** ***First*** ***Middle Initial*** ***Date of Birth***

Allergies: _____ Height: _____ Weight: _____ Blood Pressure: _____

***In lieu of entering dates below, may attach immunization record with the current provider signature/stamp.***
***If completing vaccine dates below, please include month, date & year for each required dose. Immunizations are required by the Ohio Revised Code 3313.67***

| Vaccine | Dose 1 | Dose 2 | Dose 3 | Dose 4 | Dose 5 | Dose 6 |
|---|---|---|---|---|---|---|
| Diphtheria, Tetanus, Pertussis (DTaP DTP,DT, Tdap,Td): | | | | | | |
| Polio (IPV) | | | | | | |
| Measles, Mumps, Rubella (MMR) | | | | | | |
| Varicella (Chickenpox) | | | | | | |
| Hepatitis B (HBV or Hep B) | | | | | | |
| Hepatitis A | | | | | | |
| Haemophilus Influenza type b (HIB) | | | | | | |
| PneumococcalConjugate | | | | | | |
| Influenza – * if seasonal flu vaccine is available | | | | | | |
| Meningococcal (MCV 4**) for 7th and 12th grade ONLY** | | | | | | |
| Mantoux PPD *see requirements below* | Negative | | Positive | | Comments | |

*Note: Mantoux PPD or Tuberculosis test is ONLY required for foreign exchange students and students who have come from another country. Must present proof of Mantoux II tuberculosis skin test BEFORE entering school if coming from another county.*

Immunizations are (check one): ☐ Complete for age ☐ In-process ☐ Exempt due to medical reasons

**This is to certify all of the following are true:**

- I have examined this child and found that he/she is in suitable condition for participation in group
- Based upon medical exam/physical condition at this time, he/she is free from communicable diseases
- The child has age appropriate immunizations recommended by Ohio Department of Health or exemption is on file in accordance with Ohio Revised Code 3313.671– see above for immunizations

Prior history/present examination shows child has physical condition(s) and/or limitation(s) as listed below to which school staff should be alerted (**describe/include allergies, daily medications, dietary restriction, chronic health, concerns**):

_____

_____

_____

Printed Name of Provider and Credentials (MD, DO, NP):_____

Provider Phone:_____ Provider Address: _____

**Signature of Provider**_____ **Exam Date** _____

**PRESCHOOL ONLY: In accordance with 3301-37-08, parents shall provide, prior to the date of admission or no later than 30 days after date of admission, and every 13 months from the date of examination thereafter, a medical statement affirming that the child is in suitable condition for enrollment in the program. The exam shall occur within 12 months prior to the date of admission.**