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 (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 Digital Academy (Groups - Nurse Forms - Resources): _____
_____

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☐ Hyperactive ☐ Distracted ☐ Short Attention Span ☐ Withdrawn ☐ Aggression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 with the provider.**
***1st-8th Grade NEW STUDENTS ONLY - Provide the school with your child's vaccination record OR complete section II with provider.**

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

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

Vision Screening Results: _____ Hearing Screening Results: _____

In lieu of entering dates below, may attach official immunization records.

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 the 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 or any other medical history**):

_____

_____

_____

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.