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	**Difficulty producing sounds**	YES	NO
Cancer or history of cancer	YES	NO	**Currently enrolled in speech therapy**	YES	NO
Has/ has had chickenpox	YES	NO	**Difficulty being understood by others**	YES	NO
Has/has had tuberculosis	YES	NO	**Difficulty hearing/understanding directions**	YES	NO
ADHD/ADD	YES	NO	**Currently enrolled in speech therapy**	YES	NO
Fears/Anxiety	YES	NO	**Dental concerns**	YES	NO
Tires easily	YES	NO	**Frequent bathroom use**	YES	NO
Eye/Vision problems	YES	NO	**Physical limitations or disability**	YES	NO
Wears glasses/contacts	YES	NO	**Serious illness, injury, or surgery**	YES	NO
Born premature? How many weeks?	YES	NO	**Currently taking medications, food supplements or fluoride supplements**	YES	NO
Currently under a doctor's care?	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. Please state any other health problems your child may have that would be important for the school to know: _____
_____

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

Signature of Parent _____Date _____

SECTION II - RECORD OF IMMUNIZATION– Completed by Health Care Provider

****Preschool and Kindergarten Students ONLY**** ***Grades 1-8th Immunization record(s) will be transferred from previous school**

CHILD'S NAME_____

(Please print) ***Last*** ***First*** ***Middle Initial*** ***Date of Birth***

In lieu of completing below, may attach immunization record with current provider signature/date.

If completing this form, please include month, date and 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

Provider Phone: _____ Printed Name of Provider: _____

Signature of Provider_____ **Date**_____

SECTION III - MEDICAL STATEMENT–Completed by examining "Licensed" Health Care Provider

****Preschool ONLY****

In accordance with 3301-37-08, parent shall provide, prior to 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.

CHILD'S NAME_____

(Please print) ***Last*** ***First*** ***Middle Initial*** ***Date of Birth***

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

This is to certify all of the following are true:

- I have examined this child and found that he or 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):

_____

Provider Phone:_____ Printed Name of Provider:_____

Signature of Provider_____ **Exam Date** _____