KINDERGARTEN REGISTRATION

Dear Parent/Guardian,

The State of Ohio requires the parent/guardian of a child entering kindergarten to provide certain health and emergency information no later than the ***fourteenth day of school attendance.*** The required forms are attached and include:

Ohio School Health History Form (completed by the parent/guardian)

Immunization Record

Completion of the immunization section of the Ohio Heath History Form by the parent/guardian or a copy of the child's baby book or a statement from the physician/clinic are acceptable documentation of the child's immunization record.

Ohio School Health Record Physician's Report (completed by child's physician)

Ohio School Health Record Dentist's Report (completed by child's dentist)

Return the completed forms to school by August 22, 2013.

Thank you for your cooperation in sending your child's information to school by the required deadline. If you have any questions please call the school office at 598-2100.

Sincerely,

Lois W. Eilers
Principal

Joann Ellen Grattan
School Nurse

Immunization Summary for Child Care, Head Start, Pre-School and School Attendance
Ohio

VACCINES	*FALL 2013* IMMUNIZATIONS FOR SCHOOL ATTENDANCE
DTaP/DT **Tdap/Td** Diphtheria, Tetanus, Pertussis	<u>K</u> Four (4) or more of DTaP or DT, or any combination. If all four doses were given before the 4th birthday, a fifth (5) dose is required. If the fourth dose was administered at least six months after the third dose, and on or after the 4th birthday, a fifth (5) dose is not required.* <u>1-12</u> Four (4) or more of DTaP or DT, or any combination. Three doses of Td or a combination of Td and Tdap is the minimum acceptable for children age seven (7) and up. <u>Grades 7-10</u> One (1) dose of Tdap vaccine must be administered prior to entry.**
POLIO	<u>K-3</u> Three (3) or more doses of IPV. The FINAL dose must be administered on or after the 4th birthday regardless of the number of previous doses. If a combination of OPV and IPV was received, four (4) doses of either vaccine are required.*** <u>Grades 4-12</u> Three (3) or more doses of IPV or OPV. If the third dose of either series was received prior to the fourth birthday, a fourth (4) dose is required; If a combination of OPV and IPV was received, four (4) doses of either vaccine are required.
MMR Measles, Mumps, Rubella	<u>K-12</u> Two (2) doses of MMR. Dose 1 must be administered on or after the first birthday. The second dose must be administered at least 28 days after dose 1.
HEP B Hepatitis B	<u>K-12</u> Three (3) doses of Hepatitis B. The second dose must be administered at least 28 days after the first dose. The third dose must be given at least 16 weeks after the first dose and at least 8 weeks after the second dose. The last dose in the series (third or fourth dose), must not be administered before age 24 weeks.
Varicella (Chickenpox)	<u>K-3</u> Two (2) doses of varicella vaccine must be administered prior to entry. Dose 1 must be administered on or after the first birthday. The second dose should be administered at least three (3) months after dose one (1); however, if the second dose is administered at least 28 days after first dose, it is considered valid. <u>Grade 4-7</u> One (1) dose of varicella vaccine must be administered on or after the first birthday.

NOTES:

- Vaccine should be administered according to the most recent version of the *Recommended Immunization Schedules for Persons Aged 0 Through 18 Years* or the *Catch-up Immunization Schedule for Persons Aged 4 Months Through 18 Years Who Start Late or Who Are More Than 1 Month Behind*, as published by the Advisory Committee on Immunization Practices. Schedules are available for print or download at http://www.cdc.gov/vaccines/recs/schedules/default.htm.
- *Recommended DTaP or DT minimum intervals for Kindergarten students: four (4) weeks between doses 1-2 and 2-3; six (6) month minimum intervals between doses 3-4 and 4-5. If a fifth dose is administered prior to the 4th birthday, a sixth dose is recommended, but not required.
- Vaccine doses administered ≤ 4 days before the minimum interval or age are valid (grace period). Doses administered ≥ 5 days earlier than the minimum interval or age are not valid doses and should be repeated as age-appropriate. If MMR and Varicella are not given on the same day, the doses must be separated by at least 28 days with no grace period.
- **For 7th-10th grade: If one dose of Tdap was part of the initial series, another dose of Tdap will not be required. For students in 9th or 10th grade, one dose of Td (Tetanus and diphtheria) is acceptable. Tdap can be given regardless of the interval since the last tetanus- or diphtheria-toxoid containing vaccine.
- ***The final polio dose in the IPV series must be administered at age 4 or older with at least six months between the final and previous dose.
- For additional information please refer to the Ohio Administrative Code 5101:2-12-37 for Child Care, Head Start, Pre-School and the Ohio Revised Code 3313.67 and 3313.671 for School Attendance and the ODH Director's Journal Entry (available at www.odh.ohio.gov, Immunization: Required Vaccines for Childcare and School). These documents list required and recommended immunizations and indicate exemptions to immunizations.
- Please contact the Ohio Department of Health Immunization Program at (800) 282-0546 or (614) 466-4643 with questions or concerns.

Immunization Summary for Child Care, Head Start, Pre-School and School Attendance Ohio (continued)

VACCINES	*FALL 2013* IMMUNIZATIONS FOR CHILD CARE/HEAD START AND PRE-SCHOOL ATTENDANCE
DTaP/DT Diphtheria, Tetanus, Pertussis	Four (4) doses of DTaP or DT, or any combination.
POLIO	Three (3) doses of OPV or IPV or any combination of OPV or IPV.
MMR Measles, Mumps, Rubella	One (1) dose of MMR administered on or after the first birthday.
Hib Haemophilus Influenzae Type b	Three (3) or four (4) doses depending on the vaccine type, the age when the child began the 1st dose and the last dose must be after 12 months. **or** One (1) dose if given on or after 15 months of age.
HEP B Hepatitis B	Three (3) doses of Hepatitis B. The second dose must be administered at least 28 days after the first dose. The third dose must be given at least 16 weeks after the first dose and at least 8 weeks after the second dose. The last dose in the series (third or fourth dose), must not be administered before age 24 weeks.
Varicella (Chickenpox)	1 dose of Varicella administered on or after the first birthday.

Notes:

- Vaccine doses are only considered valid if administered according to the most recent version of the *Recommended Immunization Schedules for Persons Aged 0 Through 18 Years* or the *Catch-up Immunization Schedule for Persons Aged 4 Months Through 18 Years Who Start Late or Who Are More Than 1 Month Behind*, as published by the Advisory Committee on Immunization Practices.
- Vaccine doses administered ≤ 4 days before the minimum interval or age are valid (grace period). Doses administered ≥ 5 days earlier than the minimum interval or age are not valid doses and should be repeated as age-appropriate. If MMR and Varicella are not given on the same day, the doses must be separated by at least 28 days with no grace period.
- For additional information please refer to the Ohio Administrative Code 5101:2-12-37 for Child Care, Head Start, Pre-School and the Ohio Revised Code 3313.67 and 3313.671 for School Attendance and the ODH Director's Journal Entry (available at www.odh.ohio.gov, Immunization: Required Vaccines for Childcare and School). These documents list required and recommended immunizations and indicate exemptions to immunizations.
- Please contact the Ohio Department of Health Immunization Program at (800) 282-0546 or (614) 466-4643 with questions or concerns.

Ohio School Health History

To be used for Pre-and Elementary School

School_____

Enrolled_____

Child's name	Gender ☐ Male ☐ Female	Age	Birthdate
Ethnicity ☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian American ☐ Other			
Who is the child's legal guardian?	Who does the child live with?	Child's address	
Parent/Guardian	Parent/Guardian Address	Home phone number	

Social Service History

Mark the box if you have contact with any of the following agencies:

- ☐ Child Protective Services if yes, Case worker's name:_____
- ☐ Legal/Court System
- ☐ Family Counseling Services
- ☐ Mental Health Provider
- ☐ Other:_____

Mark the box if you or your child receive any of the following medical assistance:

- ☐ SSI, Disability ☐ Healthy Start ☐ Insurance (Blue Cross/Blue Shield, HMO)
- ☐ LEAP ☐ Medicaid/CHIP ☐ Other:_____

Family History

Please list first and last name of all the child's family members including parents and siblings.

Name	Birthdate	Gender	Health Concerns	Is the child in school?	If so, where?
1.					
2.					
3.					
4.					
5.					

Perinatal History

Did the mother have any unusual physical or emotional illness during this pregnancy? ☐ Yes ☐ No If yes, explain briefly.
How old was the mother when the child was born? Was the infant born: ☐ Full term ☐ Early ☐ Late What was the infants birth weight? ___Lbs. ___Oz.
Did the infant have any sickness or problems? ☐ Yes ☐ No

Developmental History

Please give the approximate age at which this child: Walked alone_____ Spoke in sentences_____ Toilet trained_____ Dressed Self_____
How does this child's development compare to other children, such as his or her brothers/sisters or playmates? ☐ About the same ☐ Delayed ☐ Advanced

Allergies

Please list and describe allergies or reactions.

Medications/drugs
Foods/plants/animals/other
Recommended treatment if allergy is severe

Injuries, Illnesses & Hospitalizations

Please list any severe injuries, illnesses and hospitalizations including inpatient and outpatient surgical procedures.

Injuries/Illness/Hospitalizations	Age	If hospitalized, please explain.

Does your child always wear a seatbelt while riding in automobiles
☐ Yes ☐ No

Does the student wear a helmet when bicycling, skating/rollerblading or riding a motorcycle?
☐ Yes ☐ No

Medication Information

Please describe any medications that your child takes daily and frequently.

Name of Medication	What is the medication taken for?	How often is the medication taken? What time is the medication administered?

Health Conditions

Please check any medical conditions that the child currently has or has had in the past.

- ☐ Abnormal spinal curvature (Scoliosis)
- ☐ Allergies/hayfever
- ☐ Anemia
- ☐ Anaphylactic reaction
- ☐ Asthma or wheezing
- ☐ Attention deficit disorder (ADD)
- ☐ Behavior problem
- ☐ Birth or congenital malformation
- ☐ Cancer type_____
- ☐ Chickenpox when_____
- ☐ Chronic diarrhea or constipation
- ☐ Chronic ear infections
- ☐ Concern about relation with siblings or friends
- ☐ Cystic Fibrosis
- ☐ Diabetes
- ☐ Eczema/Chronic skin conditions
- ☐ Emotional problems
- ☐ Eye problems, poor vision
- ☐ Frequent headaches
- ☐ Frequent sore throats
- ☐ Heart disease type_____
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ HIV positive
- ☐ Hyperactivity
- ☐ Juvenile Arthritis
- ☐ Kidney disease type_____
- ☐ Measles (10 day)
- ☐ Meningitis or Encephalitis
- ☐ Mumps
- ☐ Mutism
- ☐ Near-drowning/Near-suffocation
- ☐ Nervous twitches or tics
- ☐ Poisoning
- ☐ Rheumatic fever
- ☐ Seizure disorder/Epilepsy
- ☐ Sickle Cell Disease
- ☐ Speech difficulties
- ☐ Stool soiling
- ☐ Toothaches or dental problems
- ☐ Tourette's Syndrome
- ☐ Urinary tract infections
- ☐ Wetting during the day or night

Behavioral History

The child is usually: ☐ Very active ☐ Normally active ☐ Rather inactive

Has your child every been violent or acted out in the following manner towards adults or children:

☐ Hitting ☐ Kicking ☐ Biting ☐ Fighting ☐ Scratching

Do you have any concern about how your child gets along with other children?

☐ Yes ☐ No If yes, explain_____

_____

_____

Please add any comments or concerns you have about your child's health, development, behavior, family, or home life that you would like the school to be aware of._____

_____

_____

_____

Is this student enrolled in special education course? ☐ Yes ☐ No

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Verification completed by:_____ Date_____

Ohio School History

Physical Assessment

School_____

Enrolled_____

Child's name	Gender ☐ Male ☐ Female	Age	Birthdate
Ethnicity ☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian American ☐ Other			

Objective Data

Height	Weight	B.P.

IMMUNIZATION shaded area required for school entry					
TYPE	**DATE MO/DAY/YR**				
DTaP DPT or DT					5th dose required if 4th dose given before age 4
DT/Td					
POLIO				Recommended. Required unless 3rd dose given before 4th B-Day.	
MMR				2nd dose required for K 2nd dose required for gr 7-12	
HEPATITIS B					
VARICELLA					
HIB (prior to age 5 only)				0-14 months; 3-4 doses 15-59 months: 1 dose	
TUBERCULIN TEST					
ROTAVIRUS (given @ 2-4-6 mo, not after 12 months)					
OTHER					

Screening Tests

Vision Date	**Hearing** Date
Distance Acuity Right_____ Left_____ Muscle Balance ☐ Pass ☐ Fail ☐ Not Done Farsightedness ☐ Pass ☐ Fail ☐ Not Done Color ☐ Pass ☐ Fail ☐ Not Done Child Wears glasses? ☐ Yes ☐ No Tested with glasses? ☐ Yes ☐ No Referral made? ☐ Yes ☐ No Specify Test/Equipment_____	Pure tone testing: Right ear ☐ Pass ☐ Fail ☐ Not Done Left ear ☐ Pass ☐ Fail ☐ Not Done Child wears hearing aid? ☐ Yes ☐ No Testing with hearing aid? ☐ Yes ☐ No Referral made? ☐ Yes ☐ No Other test (specify)_____

Speech Assessment Date

☐ Child has no discernible speech problem

☐ Child has possible problem with: ☐ Articulation ☐ Rhythm ☐ Voice ☐ Language

Speech evaluation is recommended: ☐ Yes ☐ No

Laboratory Tests

☐ Hemoglobin/Hematocrit ☐ Urine protein ☐ Urine blood ☐ Urine glucose
☐ Other_____

Physical Examination

Date of examination:_____

☐ This child is essentially within normal limits
☐ This child is not within normal limits.
Explain:

Does this child have any physical, developmental or behavioral problems? Suggest special programs, placement or attention that the school can provide.

Activities & Limitations

Can the child participate fully in the following activities:

Classroom and academic activities	☐ Yes	☐ No
Physical education classes	☐ Yes	☐ No
Competitive athletics	☐ Yes	☐ No
Contact & collision sports	☐ Yes	☐ No

Specify any limitations:

Is this child on any medications? ☐ Yes ☐ No
Explain:

Examiner's Signature_____ Date Signed_____

Examiner's Printed Name_____
Address_____
_____
Phone_____

Ohio School Health History

School_____

Oral Assessment

Enrolled_____

Child's name	Gender □ Male □ Female	Age	Birthdate
Ethnicity □ Caucasian	□ African American	□ Hispanic	□ Asian American □ Other

The following services have been performed:

- □ Examination by dentist
- □ Dental sealants
- □ Oral prophylaxis (Cleaning)
- □ Orthodontic assessment
- □ Radiographs
- □ Diagnosis
- □ Oral screening
- □ Fluoride application
- □ Prescription for fluoride supplements

The following oral hygiene instruction was provided:

- □ Toothbrushing
- □ Flossing
- □ Diet counseling related to dental health
- □ Home/school use of fluoride mouthrinse

The following statements are applicable:

- □ No apparent care needed at this time.
- □ All necessary preventive services have been performed. (Fluoride treatment, prophylaxis)
- □ No restorative services are required at this time.
- □ Further treatment is indicated. (See comments)
- □ Further appointments have been arranged. (ex. Orthodontic, restorative)

Comments:

Examiner's Signature_____ Date Signed_____

Examiner's Printed Name_____

Address_____

_____

Phone_____