Cincinnati Hills Christian Academy

Cincinnati Hills Christian Academy (2021-2022)

This form is **REQUIRED** and must be completed and signed by a physician **ANNUALLY (ONE YEAR *TO THE DAY* FROM THE DATE OF THE LAST EXAM)** for **all students under the age of 5 years.** This form must be on file with the Building Nurse prior to the first day of school. Note: if your child is less than 36 months old on August 18, 2021, the exam date must be within 6 months.

MEDICAL HISTORY AND PHYSICAL EXAMINATION

Student's Name:(First)	**(Middle)**	**(Last)**		
Date of Birth:		Visual Acuity:	**R**	**L**
gender:		Corrective Lenses:	Glasses	None
Grade:	Date:	Date of last eye exam:	______/______/______	
Height:	Weight:	Hearing Acuity:	**R**	**L**
Pulse:	Blood Pressure:	Date of last dental exam:______/_______/_______		

	Please check the appropriate boxes and explain any "Yes" answers below	Yes	No	N/A
1.	Has this student ever had any hospitalizations, surgery, injuries, or serious medical illnesses?			
2.	Does this student have any chronic physical problems?			
3.	Are there any physician-recommended physical limitations regarding participation in athletic activities?			
4.	Does this student have any drug, food, or environmental allergies? Action Plan : Yes_______ No_______			
5.	Is there any history of syncope or loss of consciousness during physical activity?			
6.	Does this student have any communicable diseases?			
7.	Are any medications, food, fluoride supplements, or dietary restrictions currently prescribed? If yes, please specify below.			
8.	Are there any Emotional or Social conditions including any fears, special routines, eating or sleeping habits?			

Important: Please attach a copy of your child's immunization records

Immunizations	Please Circle one	
Complete for age	Yes	No
In process	Yes	No

Exempt from Immunizations	Please Circle one	
Religious conviction	Yes	No
Health concern	Yes	No
Other:		

Required Assessments/Screenings:

Vision	Yes	No	Date
Hearing	Yes	No	Date
Dental	Yes	No	Date

I certify that I have on this date examined this student. On the basis of this examination this child has been examined and is free of communicable disease and is in suitable condition to fully participate in group care except as noted above.

Signature of examining Physician / Physicians Assistant / Advanced Practice Nurse (circle one)	Date of Exam:
Address:	
Phone:	

The State of Ohio requires schools to have proof of immunizations for every child enrolled in school. The dates of the immunizations must have a month, day and year to be valid. We prefer that immunizations are copied and/or faxed from your doctor's office but the second page of this form can be used.

Otto Armleder Memorial fax-513- 721-3300 **Edyth B. Linder Elementary fax-513-247-0125**

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PAGE 2: Cincinnati Hills Christian Academy Child Medical Statement for Preschool ONLY students

NOTE: The building Nurses prefer a print out of your child's immunization record from their private health care provider, but if this is not possible to obtain, then the parent may provide immunization data in the chart below including the Month, Day and year that the immunization was received.

Student Name:

Immunizations					
Type	Date (Month/Day/Year)				
DTaP DTP or DT					
Td					
Polio					
MMR					
Hep A					
Hep B					
Varicella					
Hib					
PCV13					
Rotavirus					
Influenza					