Green Local Schools

P.O. Box 218 • Green, Ohio 44232

Therese DeLucia RN, MSN
District Nurse / PSI Affiliates Inc.
(330) 896-7700 x613016
deluciatherese@greenlocalschools.org

HEALTH REQUIREMENTS
for
PRESCHOOL and ITINERANT STUDENTS
2021-2022 School Year

The requirements for school entry are set by the State of Ohio and enforced by the Summit County Health Department. The terms and conditions to be eligible to attend Green Local Schools are as follows:

PRESCHOOL/ITINERANT- All students must have a current physical and dental exam for the entire school year, required immunizations, a medical alert disclosure and eating/feeding evaluation form completed. The physical exam expires **ONE YEAR** from the date of the last physical.

Example- Child's last physical was 10-22-2020, which means it expires on 10-22-2021. Reminders will be sent to update your child's physical.

What you need for PRESCHOOL/ITINERANT:

Physical Exam (must remain current)
Dental Exam
Immunization Record
Medical Alert Disclosure
Eating/Feeding Evaluation Form

If you have any questions or need forms, please email me and I will be happy to help you through this process.

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PHYSICAL EXAMINATION

Student's name	Sex ☐ Male ☐ Female	Date of birth / /
Height	Weight	BMI percentile / BP

Screening Tests

Vision

Date performed / /

Distance Acuity	☐ R	☐ L
Muscle Balance	☐ Pass	☐ Fail
Stereopsis	☐ Pass	☐ Fail
Color	☐ Pass	☐ Fail
Child wears glasses?	☐ Yes	☐ No
Tested with glasses?	☐ Yes	☐ No
Referral made?	☐ Yes	☐ No

Hearing

Date performed / /

Pure Tone		
Right ear	☐ Pass	☐ Fail
Left ear	☐ Pass	☐ Fail
Child wears hearing aid?	☐ Yes	☐ No
Child under the care of a hearing specialist?	☐ Yes	☐ No
Referral made?	☐ Yes	☐ No

Postural

Date performed / /

☐ No abnormality noted
☐ Screening not done
☐ Referral made
Comments _____

Speech/Language

Speech assessment completed	☐ Yes	☐ No
Child has no discernible speech problem	☐ Yes	☐ No
Speech evaluation recommended	☐ Yes	☐ No

Child has possible problem with _____

Lead Poisoning

☐ Date _____ Type ☐ C ☐ V Results _____ µg/dL
☐ Date _____ Type ☐ C ☐ V Results _____ µg/dL

HGB Results _____
PRESCHOOL ONLY

Tuberculin Test

Date _____ Type _____ Results _____

Health History (Serious or chronic illnesses/injuries/surgeries)

Physical Examination Date of most recent examination / /

☐ Essentially normal ☐ Abnormalities as follows _____

Is this child able to participate fully in:

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

If limitations are advised, please specify

Does this child have any physical, developmental or behavioral issues that may affect his/her educational process?

Health Care Provider's signature	Print name	Phone ( )
Address		Date / /
City	State	Zip

Adapted from the Ohio Department of Health

Ohio Department of Health • School and Adolescent Health

Oral Assessment

Student's name	Date of birth
	/ /

The following services have been performed (please check all that apply)

☐ Examination ☐ Fluoride application ☐ Oral prophylaxis (cleaning) ☐ Prescription for fluoride supplement
☐ Orthodontic assessment ☐ Radiographs ☐ Dental sealant ☐ Treatment (restoration, pulp therapy)
☐ Other_____

The following oral hygiene instruction was provided (please check all that apply)

☐ Toothbrushing ☐ Flossing ☐ Dietary counseling ☐ Use of fluoride mouthrinse
☐ Other_____

The following statements are applicable (please check all that apply)

☐ 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. (Orthodontic, restorative)
☐ Routine recall visits recommended.

Comments

_____

_____

_____

_____

Dentist's signature	Print name	Phone ( )
Address		Date / /
City	State	ZIP

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Immunization Report

Student's name	Sex	Date of birth
	☐ Male ☐ Female	/ /

Students are required to be immunized in accordance with Ohio law (Ohio Revised Code 3313.67/3313.671).
A copy of the child's immunization record may be attached or dates may be entered below.
Please note the month, day, and year for each immunization should be on record.

Vaccine	Record complete dates (month, day, year) of vaccine doses given					
Diphtheria, Tetanus, Pertussis (DTP)						
DTaP, Tdap						
DT, Td						
Polio						
Hepatitis B (HBV)						
Measles, Mumps, Rubella (MMR)						
Varicella (Chickenpox)						
Hepatitis A						
Meningococcal (MCV4, MPSV4)						
Pneumococcal (PCV)						
Measles (Rubeola) only						
Rubella only						
Mumps only						
Haemophilus influenza Type b (Hib)						
Influenza						
Other						

2021-2022
Preschool Requirements

DTP- 4
POLIO- 3
MMR- 1
HEP B- 3
HIB- 3 or 4 if given before 15 months of age
1 if given after 15 months of age
VARICELLA- 1

This information was provided by ☐ Health Care Provider ☐ Parent/Guardian ☐ Other _____

Signature	Print name	Date
		/ /

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GREENWOOD

EARLY LEARNING CENTER

Student Medical Alert Disclosure

" THIS FORM MUST BE COMPLETED AND RETURNED "

Student Name: _____

Date of Birth: _____/_____/_____

☐ My child does not have any medical alerts that the school should be aware of.

☐ My child does have a medical alert that the school should be aware of:

Food allergies:

_____

_____

_____

Severe food allergies:

_____

_____

_____

Asthma:

_____

Diabetic:

_____

Seizure:

_____

Other:

_____

I understand that by providing this information, it will be placed in the health records by the health care staff at Greenwood Early Learning Center. I will provide any physician documentation: action plans, order(s), medication(s), and/or supplies that may be needed for my child's care.

_____ _____

Parent Signature Date

GREEN LOCAL SCHOOLS
BULLDOG STRONG

Student Services Department
1755 Town Park Boulevard
Post Office Box 218
Green, Ohio 44232-0218
330-896-7500

Dear Parents and Guardians:

Hello, my name is Joya Mitchell and I am the Director of Student Services for GLSD. I hope this letter finds you well and having had a wonderful start to the 2020-2021 school year.

In recent years, we have seen an increase in the many different ways that we feed our students, with and without disabilities, at school due to physical and/or dietary restrictions. We want to be sure that we work collaboratively with you and your child's healthcare professionals to ensure that our school team is doing everything possible to meet your child's unique feeding and dietary needs by following written physician orders.

It is important for GLSD to have documentation that your child does have special nutritional needs that require dietary modifications. We want to minimize misunderstandings, therefore, are asking that you have your healthcare professional fill out the attached feeding form. We are also asking that you provide any other documentation (swallow study, feeding clinic notes etc.) that would be beneficial for the school team so they plan accordingly for snacks and lunch daily.

If you have any further questions, please feel free to reach out to me at 330-896-7500 or mitchelljoya@greenlocalschools.org.

Sincerely,

Joya Mitchell
Director of Student Services

Green Local School District

Eating and Feeding Evaluation: Children with Special Needs

Part A

Student's Name:(Please Print)	Age:
PARENT/GUARDIAN INFORMATION:	
Parent/Guardian Name:	
Address:	
Phone #:	Emergency Phone #:
Name of School: Grade Level:	Classroom:

Does the child have a disability? If yes, describe the major life activities affected by the disability.	Yes	No
Does the child have special nutritional or feeding needs? If yes, complete PART B of this form and have it signed by a licensed physician.	Yes	No
If the child is not disabled, does the child have special nutritional or feeding needs? If yes, complete PART B of this form and have it signed by a recognized medical authority.	Yes	No

If the child does not require special meals, the parent can sign at the bottom and return the form to the main office secretary.

Part B

List any dietary restrictions or special diet:	
List any allergies or food intolerance to avoid:	
List foods to be substituted:	
List foods that need the following change in texture. Cut up or chopped into bite size pieces: Finely ground: Pureed:	If all foods need to be prepared in this manner, indicate "ALL".

List any special equipment or utensils that are needed:

Indicate any other comments about the child's eating or feeding patterns:

Parent Signature:_____	Date: _____
Physician or Medical Authority's Signature:_____	Date:_____

Information Card:

Student's Name: _____ Teacher's Name: _____

Special Diet or Dietary Restrictions:

Food Allergies or Intolerances:

Food Substitutions:

Foods requiring texture modifications:

Chopped:

Finely Ground:

Pureed or Blended:

Other diet modifications:

Feeding techniques:

Supplemental feedings:

Physician or Medical Authority:

Name: **Address:** **Telephone:** **Fax:**	**Name:** **Address:** **Telephone:** **Fax:**

Additional Medical Contacts (feeding clinic etc.):

Name: **Telephone:** **Fax:**	**Name:** **Telephone:** **Fax:**

Person Completing Form:

Name:_____ Signature:_____	Date:_____

***Please, provide a copy of your child's swallow study if one has been completed.**