OHIO DEPARTMENT OF EDUCATION

DIVISION OF EARLY CHILDHOOD EDUCATION

RITTMAN EARLY LEARNING CENTER 2024-25 - MEDICAL FORM

Section I - Child Medical Information

Child's Name _____ Age _____

Date of Birth _____ Height _____ Weight _____

Immunizations:		**Exempt from Immunization:**	
Complete for Age	○ Yes ○ No	Religious Conviction	○ Yes ○ No
In Process	○ Yes ○ No	Health	○ Yes ○ No
		Other	_____

Limitations or health conditions, including allergies, medications, and dietary restrictions.

Section II - Child Medical Statement Verification

Physician/Clinic/Hospital Name _____ Provider Address _____

Provider Phone Number _____ Provider City _____ Provider State _____ Provider Zip _____

Check box of examining medical professional:

- ☐ Physician
- ☐ Physician's Assistant
- ☐ Advanced Practice Nurse

This child has been examined and is in suitable condition to participate in group care.

Signature of Medical Professional _____ Date of Exam _____

Programs funded through the Ohio Department of Education must have written policies and procedures to ensure that children have received comprehensive health screenings and/or that families are informed of the importance of health screenings and the resources to obtain them.

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RITTMAN EARLY LEARNING CENTER 2024-25 - DENTAL FORM

Name of Child ____ Male ____Female	
Date of Birth	
Child's Current Age	
Parent(s)/Guardian(s) Name	

1. Is the child now receiving any of the following? If YES, include length of time receiving fluoride.
   - Topical fluoride application ____No ____Unknown ____Yes
   - Fluoridated water ____No ____Unknown ____Yes
   - Fluoride supplement diet ____No ____Unknown ____Yes
   - ____Tablets ____Liquid
2. Does the child have any of the following? If YES, provide details.
   - Allergies ____Yes ____No
   - Asthma ____Yes ____No
   - Bleeding ____Yes ____No
   - Diabetes ____Yes ____No
   - Epilepsy ____Yes ____No
   - Heat/vascular disease ____Yes ____No
   - Liver disease ____Yes ____No
   - Rheumatic fever ____Yes ____No
   - Sickle cell disease ____Yes ____No
   - Other (Please list.) _____
3. Does the child have any trouble with teeth, gums, or mouth? ____Yes ____No
   - If so, what kind? _____
4. Child has previously seen a dentist? ____Yes ____No
   - Dentist's Name _____ Date of last visit _____
5. Child is under a physician's care? ____Yes ____No
   - Physician's Name _____
6. Child is receiving medication? ____Yes ____No
7. PLEASE PROVIDE A <u>WRITTEN SUMMARY OF SERVICES REQUIRED</u> (on the back of this form):
   - for the relief of pain or infection
   - restoration and/or pulp therapy of decayed primary and permanent teeth
   - extraction of non-restorable teeth
   - dental prophylaxis and instruction in self-care oral hygiene procedures

Dentist's Name (Print)	
Complete Address	
Phone	Date of Current Visit:
License No. Tax ID No.	

The annual dental exam by a dentist is an oral diagnostic procedure which should include radiographs (x-rays) only if the dentist determines that they are absolutely necessary. This form should be completed within 90 days of the child's entrance into the program. Developmental dental history should be part of health screening completed within 45 days of entrance.