# KINDERGARTEN MEDICAL INFORMATION

## MEDICAL/DENTAL FORMS

All Kindergarten students will be required to have the following:

A. Physical Form- completed by physician
B. Dental Form- completed by dentist
C. Health History- completed by parent
D. Immunization Record- **Immunizations must be up to date at the start of the school, otherwise students can be excluded from school**

## STUDENT MEDICATION

Any student requiring medication **MUST** have a Medication Form on file at school. This includes both Prescription (signed by physician) and Over the Counter Medications. ** Cough drops are considered a medication.

## MEDICAL CONCERNS

If your child has a Chronic Health Condition such as severe allergies requiring an Epi-Pen; Asthma-needing an inhaler; Diabetes or anything you feel needs to be brought to the attention of the School Nurse, please contact the nurse @ 485-8179.

## When to KEEP YOUR CHILD HOME:

- Fever of 100 or higher. Fever Free for 24 hours without medication
- Vomiting/diarrhea- keep home 24 hours after last episode
- Undiagnosed rash- need a physician note to return to school
- Strep Throat- completed 24 hours of antibiotic
- Severe Cough/Cold- especially with green/yellow nasal drainage
- Red, watery, burning, itchy eyes or yellowish drainage
- Nits/Lice- must be cleared by the Clinic

The above symptoms/conditions may mean the start of a communicable disease or nuisance condition that could affect many other children in your child's classroom. Your child may also be too sick to learn in school that day. In fairness to **ALL** children, keep your child home until you can determine what else may be developing. Contact your school nurse at 485-8179 if you have any questions.

# KINDERGARTEN
# IMMUNIZATION REQUIREMENTS

**DTaP/DTP/DT/Tdap/Td**: (Diphtheria, Tetanus, Pertussis) 5 doses of DTaP/DPT or DT or any combination, if the fourth dose was administered prior to the 4th birthday

**Polio:** 4 doses of OPV or IPV or any combination of OPV or IPV. The fourth dose **must** be administered on or after the 4th birthday regardless of the number of previous doses.

**MMR:** (Measles, Mumps, Rubella) 2 doses of MMR. Dose 1 must be administered on or after the 1st birthday. The second dose must be administered at least 28 days after dose 1.

**Hep B:** (Hepatitis B) 3 doses of Hepatitis B

**Varicella:** (Chicken Pox) 2 doses of varicella vaccine

A **complete** Immunization Record **must** be on file at school prior to the start of school. Students may be excluded from school if the record in incomplete.

# OHIO SCHOOL HEALTH RECORD
# PHYSICIAN'S REPORT

Child's Name ________________ Male _____ Female _____ Age _____ Date __________

## OBJECTIVE DATA

Height ____________ ( %) Weight ______________ ( %) B.P. _____/_____

## SCREENING TESTS

Date performed ___________

| **Vision** | **Hearing** |
|---|---|
| Distance Acuity R _____ L _____ | Audiometric thresholds: |
| Muscle Balance pass _____ fail _____ not done _____ | R – ear pass _____ fail _____ not done _____ |
| Farsightedness pass _____ fail _____ not done _____ | L – ear pass _____ fail _____ not done _____ |
| Color pass _____ fail _____ not done _____ | Other tests (specify) _______________ |
| Child wears glasses? yes _____ no _____ | Child wears hearing aid? yes _____ no _____ |
| Tested with glasses? yes _____ no _____ | Tested with hearing aid? yes _____ no _____ |
| Referral made: yes _____ no _____ | Referral made? yes _____ no _____ |

## SPEECH / LANGUAGE

Speech assessment: done _____ not done _____
Child has no discernible speech problem _____
Child has possible problem with:
Disorders: (check) Articulation _____ Rhythm _____ Voice _____ Language _____
Speech evaluation recommended: Yes _____ No _____

## LABORATORY TESTS

Hematocrit / Hemoglobin __________ Urine protein __________ Urine blood __________
Urine glucose __________ Other: _______________________________________

## PHYSICAL EXAMINATION

Date examined __________ Essentially normal __________ Abnormalities as follows:

_______________________________________________________________

_______________________________________________________________

_______________________________________________________________

Is this child able to participate fully in the following?

A. Classroom and academic activities? Yes __________ No __________
B. Physical education classes: Yes __________ No __________
C. Competitive athletics? Yes __________ No __________
D. Contact and collision sports? Yes __________ No __________

If limitations are advised, please specify those limitations:

_______________________________________________________________

_______________________________________________________________

_______________________________________________________________

If this child has any physical, developmental or behavioral problems, how can the school assist with special programs placement or attention?

______________________________________________

______________________________________________

______________________________________________

## PHYSICIAN'S ASSESSMENT

**Problem list** **Recommendation for school management**

**1.** ______________________________________________

**2.** ______________________________________________

**3.** ______________________________________________

**4.** ______________________________________________

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

**PLEASE PRINT OR STAMP**

Physician's name ____________________ Physician's signature ____________________

Address ______________________________________________

Phone ____________________ Date signed ____________________

# Ohio School Health Record
# Dentist's Report

| Child's Name | Sex ☐ Male Female | Age | Date |
|---|---|---|---|
| | | | |

The following services have been performed:

- ☐ Examination
- ☐ Radiographs
- ☐ Prescription for fluoride supplements
- ☐ Diagnosis
- ☐ Oral prophylaxsis
- ☐ Topical application of fluoride

The following services have been performed:

- ☐ Toothbrushing
- ☐ Diet counseling reflecting relation of diet to dental health
- ☐ Flossing
- ☐ Home/school use of fluoride mouthrinse

The following services have been performed:

- ☐ All necessary services have been performed
- ☐ Diet counseling reflecting relation of diet to dental
- ☐ No restorative services are required at this time
- ☐ Further appointments have been arranged

Comments: ______________________________

**Please print or stamp**

| Dentist's Name | Dentist's Signature |
|---|---|
| Address | Date Signed |
| Phone | |

Kindergarten ONLY

Ohio Department of Health • School and Adolescent Health

# Health History

| Student's name | Sex<br>☐ Male ☐ Female | Date of birth<br>/ / |
|---|---|---|

**Family Health History** Please list allergies, heart problems, diabetes, cancer or other serious health conditions.

| |
|---|
| Father |
| Mother |
| Brothers and Sisters |

**Birth and Developmental History** ☐ No unusual birth or developmental history

Did the mother have any unusual physical or emotional illness during this pregnancy? ☐ Yes ☐ No

Was infant born full term? ☐ Yes ☐ No Did the infant have any sickness or problems? ☐ Yes ☐ No

Briefly explain illness or problems.

How does the child's development compare to other children, such as his or her brothers/sisters or playmates?

☐ About the same ☐ Delayed ☐ Advanced

**Student Health Conditions**

☐ **YES,** my child receives regular medical/health care for the following conditions: ☐ **NO** medical conditions

| | | |
|---|---|---|
| ☐ Allergies | ☐ Diabetes | ☐ Seizure disorder |
| ☐ Asthma | ☐ Depression | ☐ Sickle cell anemia |
| ☐ ADD/ADHD | ☐ Ear problem/hearing difficulty | ☐ Skin conditions |
| ☐ Autism | ☐ Emotional concerns | ☐ Speech problems |
| ☐ Behavior concerns | ☐ Headaches | ☐ Traumatic brain injury |
| ☐ Birth/congenital malformations | ☐ Heart problems | ☐ Vision problems (glasses, contacts) |
| ☐ Bone/muscle/joint problems | ☐ Hemophilia | ☐ Other |
| ☐ Blood problems | ☐ Juvenile arthritis | ☐ Other |
| ☐ Bowel/bladder problems | ☐ Lead poisoning | ☐ Other |
| ☐ Cancer | ☐ Migraines | ☐ Other |
| ☐ Cystic fibrosis | ☐ Neuromuscular disorder | ☐ Other |

Please explain any conditions above or any reasons for hospitalizations.

Please indicate any allergies your child may have.

| Allergy type | Reaction | School restrictions or recommended actions |
|---|---|---|
| ☐ Bee/Insect | | |
| ☐ Food | | |
| ☐ Medication | | |
| ☐ Other | | |

## Health History continued

Please list any prescription and over the counter medication that your child takes on a regular basis.

| Medication and dose | Time | Reason |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

Do any health and/or medical conditions require school restrictions, modifications, and/or intervention?

☐ Yes ☐ No If YES, please explain.

Does the student require any special procedures and/or treatments for their health condition(s)?

☐ Yes ☐ No If YES, please explain.

Please indicate any other information about your child's health or development that you think would be helpful for the school to know.

| Form completed by | Relationship to student | Date / / |
|---|---|---|
| | | |