

Greenville Elementary
Greenville City Schools
1111 N. Ohio St.
Greenville, Ohio 45331
(937) 548-1013 phone
(937) 548-2175 fax

Spring 2026

Dear Parent or Guardian:

The Greenville Board of Education requires physical examinations and complete immunizations for all students entering kindergarten, and any student entering first grade (if the child did not previously attend kindergarten at Greenville City Schools). A dental examination is strongly recommended. You may use the attached form.

The School Health Examination Record and Immunization

Record must be returned by Monday, August 10, 2026. Please take forms to Greenville Elementary or mail forms to Greenville Elementary at above address. **Do NOT take form to Memorial Hall.** **Please be sure your child's name and birth date are on the physical and dental forms.**

Sections 3313.671 and 37101.13 of the Ohio Revised Code require that all pupils must **present written evidence (exact dates)** of having received, or are in the process of receiving, immunizations as required by the State of Ohio to enter kindergarten. Immunization requirements must be turned in by the 14th day of school for the student to remain in school. The following are the requirements for all kindergarten students:

Immunization	Required Dose
DTaP/DTP/DT/Td	5 doses
Polio	4 doses
MMR	2 doses
Hep B	3 doses
Varicella (chicken pox)	2 doses

If there is a medical reason why immunizations cannot be obtained, it must be reported in writing by the family physician. Objection on religious grounds is a valid exemption only when a written statement to this effect is signed by a parent or guardian.

The Darke County Health Department will provide immunizations on Tuesdays from 8:00 AM to 10:30 AM and 2:00 PM to 5 PM. The Darke County Health Department is located at 300 Garst Avenue, Greenville, Ohio. Clinics are walk-in. No appointments needed.

Sincerely,

Beth Shellhaas, RN, BSN, CSN
School Nurse

Ohio Department of Health • School and Adolescent Health

Health History

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

Physical Examination

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

Screening Tests

Vision		Hearing		Postural	
Date performed / /		Date performed / /		Date performed / /	
Distance Acuity	☐ R ☐ L	Pure Tone		☐ No abnormality noted	
Muscle Balance	☐ Pass ☐ Fail	Right ear	☐ Pass ☐ Fail	☐ Screening not done	
Stereopsis	☐ Pass ☐ Fail	Left ear	☐ Pass ☐ Fail	☐ Referral made	
Color	☐ Pass ☐ Fail	Child wears hearing aid?	☐ Yes ☐ No	Comments	
Child wears glasses?	☐ Yes ☐ No	Child under the care of a hearing specialist	☐ Yes ☐ No		
Tested with glasses?	☐ Yes ☐ No	Referral made?	☐ Yes ☐ No		
Referral made?	☐ Yes ☐ No				

Speech/Language

Speech assessment completed	☐ Yes ☐ No	☐ Date _____ Type ☐ C ☐ V Results _____ µg/dL
Child has no discernible speech problem	☐ Yes ☐ No	☐ Date _____ Type ☐ C ☐ V Results _____ µg/dL
Speech evaluation recommended	☐ Yes ☐ No	Tuberculin Test
Child has possible problem with _____		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?	

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

Ohio Department of Health • School and Adolescent Health

Immunization Report

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

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

Signature	Print name	Date / /
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Oral Assessment

Student's name	Date of birth / /
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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