



**MILFORD**

Exempted Village Schools

## CENTRAL REGISTRATION

### Kindergarten

Milford Exempted Village School District's Vision Statement is to inspire and prepare our students to reach their fullest potential in a diverse and dynamic world.

**Central Registration appointments can be scheduled by calling (513)576-4163.**

Milford Board of Education  
777 Garfield Avenue  
Milford, OH 45150

Please bring your child's completed enrollment packet along with other documentation required for enrollment to your appointment. Once the enrollment process is completed, your student's school will be contacted and you will be given a start date for your child.

If you have any questions regarding any of these forms or registration requirements, please contact the Central Registration Department at (513)576-4163.



**MILFORD**

Exempted Village Schools

## KINDERGARTEN REGISTRATION CHECKLIST

Student Name: \_\_\_\_\_ School: \_\_\_\_\_

### DOCUMENTS REQUIRED FOR REGISTRATION

- Child's Original Birth Certificate or Passport (Bureau of Vital Statistics (614) 466-2531)
- Parent/Guardian Driver's License or State Issued ID Card
- Proof of Residency (Utility bill, lease/rental agreement\*, deed, purchase contract)  
\*Rental/Lease agreement must list names of all occupants
  - Residency Affidavit (*This affidavit is used when the parent/legal guardian and child are living in a domicile belonging to another person.*)
- Grade Documentation (*if applicable*)
- Custody Papers/Guardianship Papers (*if applicable*)
- Special Education paperwork - IEP/ETR (*if applicable*)
- Child's current immunization record

### FORMS IN THE REGISTRATION PACKET

- Student Registration Form
- Records Request Form
- Emergency Medical Authorization Form
- Free and Reduced Lunch Parent Disclosure Form
- Free and Reduced Lunch Application
- Medical Forms
  - ALL GRADES** - HEALTH HISTORY FORM (*completed by parent/guardian*)
  - KINDERGARTEN** - PHYSICAL EXAMINATION FORM (*completed by physician*)
  - KINDERGARTEN** - ORAL ASSESSMENT FORM (*completed by dentist*)



**MILFORD**

Exempted Village Schools

# STUDENT REGISTRATION FORM

Office Use Only:

Student ID # \_\_\_\_\_

Enrollment Date: \_\_\_\_\_

School: \_\_\_\_\_ Grade \_\_\_\_\_

Male  Female

Student's Legal Last Name      Legal First Name      Legal Middle Name      Preferred Name

Date of Birth (mm/dd/yyyy)

Place of Birth (City)

(State)

(Country)

Home Address: \_\_\_\_\_  
Street      Apt. #      City      Zip Code

Home Phone

Mother's Maiden Name

Child's Native Language

## Legal Guardianship

Are you the biological/adoptive parent(s) of the child?  Yes  No

If no, what is your relationship to the child? \_\_\_\_\_

Status of BIOLOGICAL/ADOPTIVE Parents:  Married  Divorced  Widowed  Separated  Single/Never married

If divorced, who has legal custody?  Mother  Father  Shared Parenting

If foster/guardian, what district did the biological parent(s) reside in at the time you received custody? \_\_\_\_\_

If foster/guardian, please list Case Manager/Court Liaison: \_\_\_\_\_

Case manager/Court Liaison contact information: \_\_\_\_\_

Please complete information on father and mother, including contact numbers, regardless of marital status.

### Circle: Father/Guardian/Foster Parent

### Circle: Mother/Guardian/Foster Parent

RESIDES here

RESIDES here

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell/Pager: \_\_\_\_\_

Cell/Pager: \_\_\_\_\_

Email: \_\_\_\_\_

Email: \_\_\_\_\_

Name of Employer: \_\_\_\_\_

Name of Employer: \_\_\_\_\_

Business Phone: \_\_\_\_\_

Business Phone: \_\_\_\_\_

Step-Father (if applicable): \_\_\_\_\_

Step-Mother (if applicable): \_\_\_\_\_

Work Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Cell/Pager: \_\_\_\_\_

Cell/Pager: \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Phone: \_\_\_\_\_ Work/Cell: \_\_\_\_\_

Phone: \_\_\_\_\_ Work/Cell: \_\_\_\_\_

## Siblings

Name	Age	Grade	Lives with...
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List any medical problems the student has: \_\_\_\_\_  
 \_\_\_\_\_

## Citizenship/Ethnic Status

**Citizenship Status:**    U.S. Citizen    Non U.S. Citizen/Immigrant\*    Foreign Exchange Student

\*Immigrant students are those who: are age 3 – 21, were not born in the United States, and have not attended one or more schools in any one or more of the states for more than three academic years.

Is the student of Hispanic/Latino heritage?    Yes    No

Persons of Mexican, Puerto Rican, Cuban, Central or South America, or other Spanish culture or origin regardless of race.

Is the student from one or more races using the following 5 racial/ethnic groups?   **Check all that apply.**

Race/Ethnicity:	Definitions as defined by the Ohio Department of Education
<input type="checkbox"/> White	Persons having origins in any of the original peoples of Europe, North Africa, or the Middle East.
<input type="checkbox"/> Black/African American	Persons having origins in any of the Black racial groups of Africa.
<input type="checkbox"/> Asian	Persons having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian sub-continent. This area includes Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
<input type="checkbox"/> American Indian/Alaskan Native	Persons having origins in any of the original peoples of North America and who maintain cultural identification through tribal affiliation or community recognition.
<input type="checkbox"/> Native Hawaiian or Other Pacific Islander	Persons having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

## Special Services

Has your child ever attended Special Education classes?    Yes    No

Does your child have a 504 plan?    Yes    No

(Disability required only reasonable accommodations)

Has your child had an evaluation (M.F.E. : Multi-Factored Evaluation is an assessment of your child in all areas related to the suspected disability) in the past 3 years?    Yes    No

If yes, what is the date of the evaluation?   \_\_\_\_\_

If yes, is there a current IEP? (Individualized Education Plan)    Yes    No

Has your child been identified as Gifted?    Yes    No

If yes, did your child receive Gifted Services at prior school?    Yes    No

If yes, grade of placement in Gifted Program?   \_\_\_\_\_

If you answered "Yes" to any question in this section, please note any special needs information that may help us place your student:

\_\_\_\_\_

\_\_\_\_\_

### Home Language Survey

*Please complete this section if your child speaks a language other than English at home or was born outside of the United States.*

Students Name: \_\_\_\_\_

Father's Nationality: \_\_\_\_\_

Mother's Nationality: \_\_\_\_\_

What languages can you (parent/guardian) speak?

Mother/Guardian:

Father/Guardian:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

What language did your child speak when he/she first learned to talk? \_\_\_\_\_

What language does your child use most frequently at home? \_\_\_\_\_

What language do you use most frequently to speak to your child? \_\_\_\_\_

What language do the adults at home most often speak? \_\_\_\_\_

Does anyone in your home read English?  Yes  No

If yes, list name of person: Name \_\_\_\_\_ Relationship to child \_\_\_\_\_

How long has your child attended school in the United States? \_\_\_\_\_

What year did your child first attend school in the United States? \_\_\_\_\_

Did your child ever receive English instruction

before entering Milford Schools?  Yes  No

How often? \_\_\_\_\_ Where? \_\_\_\_\_

Where did your child last attend school? \_\_\_\_\_

How long was your child enrolled there? \_\_\_\_\_

### Prior School History

Has your child ever been enrolled in Milford Schools?  Yes  No

If so, what year was he/she withdrawn? \_\_\_\_\_

**LAST PUBLIC/PRIVATE SCHOOL ATTENDED:** \_\_\_\_\_

**School's address :** \_\_\_\_\_

**School phone:** \_\_\_\_\_ **School Fax:** \_\_\_\_\_

Is your child currently **expelled** or **suspended** from your previous district?  Yes  No

### Parent/Guardian Signature *Required to complete Registration Form*

I, the undersigned, do hereby state and declare under penalty of falsification (\*) that I am the parent or legal guardian of the above named student and that this registration information is true and correct.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

(\*) Falsification under Ohio Revised Code section 2921.13 is a misdemeanor of the first degree punishable by a maximum of six (6) months imprisonment or a fine of \$1,000 or both.



# STUDENT RECORDS REQUEST

## MILFORD

Exempted Village Schools

Please release all appropriate past and present academic, discipline, medical, confidential and special education records (including psychological information, diagnostic summaries, IEP's, etc.) on the student named below. Records should be mailed/faxed to the school address indicated below.

Student Name	Birth Date	Grade
Signature of Parent/Guardian	Relationship	Date

Name and address of school releasing records:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Phone: \_\_\_\_\_  
 Fax: \_\_\_\_\_  
 Contact: \_\_\_\_\_

### The following is to be filled out by the prior school, IF APPLICABLE:

The records for the above student CANNOT be released because (check all that apply):

Fees due (Amount owed: \_\_\_\_\_)       Grades incomplete       No records available  
 Books not returned (Titles): \_\_\_\_\_

If the student has been expelled, please include details of expulsion (reason and dates): \_\_\_\_\_

\_\_\_\_\_

Signature of person completing form	Date
-------------------------------------	------

**McCormick Elementary**  
 751 Loveland-Miamiville Road  
 Loveland, OH 45140  
 Phone: (513) 575-0190  
 Fax: (513) 575-4019  
 Attn: Marcia Dauw

**Pattison Elementary**  
 5330 South Milford Road  
 Milford, OH 45150  
 Phone: (513) 831-6570  
 Fax: (513) 831-9693  
 Attn: Kathy Barrows

**Milford Jr. High School**  
 5735 Pleasant Hill Road  
 Milford, OH 45150  
 Phone: (513) 248-3444  
 Fax: (513) 248-3443  
 Attn: Connie Stevens

**Meadowview Elementary**  
 5556 Mount Zion Road  
 Milford, OH 45150  
 Phone: (513) 831-9170  
 Fax: (513) 831-9340  
 Attn: Diane Moore

**Seipelt Elementary**  
 5640 Cromley Drive  
 Milford, OH 45150  
 Phone: (513) 831-9460  
 Fax: (513) 248-5443  
 Attn: Carolyn Haskins

**Milford High School - NGC**  
 One Eagles Way  
 Milford, OH 45150  
 Phone: (513) 576-2278  
 Fax: (513) 576-2277  
 Attn: Pat Burke

**Mulberry Elementary**  
 5950 Buckwheat Road  
 Milford, OH 45150  
 Phone: (513) 722-3588  
 Fax: (513) 722-4584  
 Attn: Kathi Swift

**Boyd E. Smith Elementary**  
 1052 Jer-Les Drive  
 Milford, OH 45150  
 Phone: (513) 575-1643  
 Fax: (513) 575-2835  
 Attn: Jan Wolker

**Milford High School**  
 One Eagles Way  
 Milford, OH 45150  
 Phone: (513) 576-2203  
 Fax: (513) 831-9714  
 Attn: Chris Duffy

**MILFORD EXEMPTED VILLAGE SCHOOL DISTRICT**  
**EMERGENCY MEDICAL AUTHORIZATION**

2012-13

Á

**Purpose:** To enable parents and guardians to authorize the provisions of emergency treatment or transportation for children who become ill or injured while under school authority, or during an emergency situation, when parents cannot be reached. **Notify the school immediately if any information changes.** (Please print).

Student's Name \_\_\_\_\_ Teacher/Homeroom/Grade \_\_\_\_\_

Student's Address \_\_\_\_\_ Phone No. \_\_\_\_\_

(Street Address)

(Zip Code)

Male or Female \_\_\_\_\_ Date of Birth \_\_\_\_\_

Who is/are the legal guardian(s) of this child? \_\_\_\_\_

List the names, relationships to the student, and phone numbers of those people the school should call in the event of accident, illness, or school emergency. **This list should include the parent(s)/legal guardian(s) and should be in the order of calling preference, after attempts to call the parent(s)/guardian(s) are made.**

NAME	RELATIONSHIP (Parent, Relative, Etc.)	PHONE NUMBERS		CELL/PAGER	E-MAIL
		HOME	WORK		
(Parent/Guardian)	_____	_____	_____	_____	_____
(Parent/Guardian)	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

I understand that my child may be released to anyone on the above list if ill, injured, or if an emergency occurs, and he/she must leave school.

Signature of Parent/Legal Guardian \_\_\_\_\_

Date \_\_\_\_\_

Medical Problems/Allergies/Special Needs:

\_\_\_ Diabetes \_\_\_ Asthma \_\_\_ Seizures \_\_\_ Bee or Insect Sting \_\_\_ Other \_\_\_ Orthopedic

\_\_\_ Visually or Hearing Impaired \_\_\_ Medication or Food Allergy \_\_\_ Emotional Problem \_\_\_ Learning Disability

History of Concussion(s) \_\_\_\_\_

Please provide detailed information regarding any above marked areas:

.  
. .  
. .  
. .  
..

For educational purposes, special medical problems, physical impairments or other facts concerning your child's medical history may be shared with teachers or other support staff involved in the academic setting. If you do **not** consent for the sharing of this information, you are required to state this in writing and submit your statement with this form to your school administrator.

**TURN OVER**

**Please Complete:**

Student's Name \_\_\_\_\_ Teacher/Homeroom/Grade \_\_\_\_\_

Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

Specialist: \_\_\_\_\_ Phone: \_\_\_\_\_

Hospital (1<sup>st</sup> choice) \_\_\_\_\_ (2<sup>nd</sup> choice) \_\_\_\_\_

**Please complete EITHER Part I or Part II below:**

**Part I: Granting Consent**

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by the previously-named doctor, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and, (2) the transfer of the child to any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted:

.  
.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Legal Guardian

**Part II: Refusal to consent (DO NOT COMPLETE IF YOU COMPLETED PART I).**

I do NOT give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action: (MUST BE COMPLETED IF REFUSING CONSENT FOR TREATMENT)

.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Legal Guardian

Sec. 3313.71.2. AS USED IN THIS SECTION, "PARENT" MEANS PARENT AS DEFINED IN SECTION 3321.01 OF THE REVISED CODE.

(A) Annually the board of education of each city, exempted village, local, and joint vocational school district shall, before the first day of October, provide to the parent of every pupil enrolled in schools under the board's jurisdiction, an emergency medical authorization form that is an identical copy of the form contained in division (B) of this section. Thereafter, the board shall, within thirty days after the entry of any pupil into a public school in this state for the first time, provide his parent, either as part of any registration form which is in use in the district, or as a separate form, an identical copy of the form contained in division (B) of this section. When the form is returned to the school with Part I or Part II completed, the school shall keep the form on file, and shall send the form to any school of a city, exempted village, local or joint vocational school district which the pupil is transferred. Upon request of his parent, authorities of the school in which the pupil is enrolled may permit the parent to make changes in a previously filed form, or to file a new form.

If a parent does not wish to give such written permission, he shall indicate in the proper place on the form the procedure he wished school authorities to follow in the event of a medical emergency involving his child.

Even if a parent gives written consent for emergency treatment, when a pupil becomes ill or is injured and requires emergency medical treatment while under school authority, or while engaged in extra-curricular activity authorized by the appropriate school authorities, the authorities of his school shall make reasonable attempts to contact the parent before treatment is given. The school shall present the pupil's emergency medical authorization form or copy thereof to the hospital or practitioner rendering treatment.

Nothing in this section shall be construed to impose liability on any school official or school employee, who, in good faith, attempts to comply with this section.

(B) The emergency medical authorization form provided for in division (A) of this section is as follows: (See reverse side.)

Revised: 6/80	Reviewed: 1999
Revised: 7/20/00	Reviewed: 6/90
Revised: 3/22/02	Reviewed: 1994
Revised: 5/15/03	Reviewed: 1996
Revised: 5/20/04	Reviewed 3/21/96
Reviewed: 1997	Reviewed: 1998

Revised: 5/19/2007, 2008, 2009, 2010, 2011, 2012

Milford Exempted Village School District, Milford, Ohio

## **KINDERGARTEN REGISTRATION - MEDICAL FORM CHECKLIST**

The following medical forms are included in this packet.  
Please refer to detailed information listed next to the form's name.

- Physical Examination and Immunization Report**  
(completed by health care provider)
- Oral Assessment**  
(completed by dentist)

**Ohio State Law requires that all students meet the State's immunization requirements. The law also mandates that the immunization requirements be met within FIFTEEN days from the date of enrollment. Proof of immunization must be received by the clinic no later than the end of the school day on **September 14<sup>th</sup>, 2012** or the student will be excluded from school.**

All Kindergarten students will be required to have written documentation of:

- ⇒ **3 doses of Hepatitis B vaccine**  
The second dose must be administered at least 28 days after the first dose. The third dose must be administered at least 2 months after the second dose and at least 4 months after the first dose, and at least 6 months of age.
- ⇒ **5 doses of DtaP, DTP, DT vaccine** or any combination, if the 4<sup>th</sup> dose was administered prior to the 4<sup>th</sup> birthday.
- ⇒ **4 doses of Polio vaccine** of any combination of OPV or IPV. The final dose must be administered on or after the 4<sup>th</sup> birthday regardless of the number of previous doses.
- ⇒ **2 doses of MMR (Measles, Mumps, Rubella) vaccine**  
The first dose must be administered on or after the child's first birthday and the second dose at least 28 days later.
- ⇒ **2 dose of Varicella (Chicken Pox) vaccine**  
The first dose must be administered on or after the child's first birthday and the second dose at least 28 days later.

## Ohio Department of Health • School and Adolescent Health Health History

Student's name	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth /    /
----------------	--	-------------------------

**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? <input type="checkbox"/> Yes <input type="checkbox"/> No
Was infant born full term? <input type="checkbox"/> Yes <input type="checkbox"/> No      Did the infant have any sickness or problems? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> About the same <input type="checkbox"/> Delayed <input type="checkbox"/> Advanced

**Student Health Conditions**

<input type="checkbox"/> <b>YES</b> , my child receives regular medical/health care for the following conditions:	<input type="checkbox"/> <b>NO</b> medical conditions	
<input type="checkbox"/> Allergies	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Seizure disorder
<input type="checkbox"/> Asthma	<input type="checkbox"/> Depression	<input type="checkbox"/> Sickle cell anemia
<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Ear problem/hearing difficulty	<input type="checkbox"/> Skin conditions
<input type="checkbox"/> Autism	<input type="checkbox"/> Emotional concerns	<input type="checkbox"/> Speech problems
<input type="checkbox"/> Behavior concerns	<input type="checkbox"/> Headaches	<input type="checkbox"/> Traumatic brain injury
<input type="checkbox"/> Birth/congenital malformations	<input type="checkbox"/> Heart problems	<input type="checkbox"/> Vision problems (glasses, contacts)
<input type="checkbox"/> Bone/muscle/joint problems	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Other _____
<input type="checkbox"/> Blood problems	<input type="checkbox"/> Juvenile arthritis	<input type="checkbox"/> Other _____
<input type="checkbox"/> Bowel/bladder problems	<input type="checkbox"/> Lead poisoning	<input type="checkbox"/> Other _____
<input type="checkbox"/> Cancer	<input type="checkbox"/> Migraines	<input type="checkbox"/> Other _____
<input type="checkbox"/> Cystic fibrosis	<input type="checkbox"/> Neuromuscular disorder	<input type="checkbox"/> 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
<input type="checkbox"/> Bee/Insect		
<input type="checkbox"/> Food		
<input type="checkbox"/> Medication		
<input type="checkbox"/> 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    /    /
-------------------	-------------------------	----------------

## Ohio Department of Health • School and Adolescent Health

# Physical Examination

Student's name		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of birth / /	
Height	Weight	BMI percentile		BP	

### Screening Tests

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

### Speech/Language

### Lead Poisoning

Speech assessment completed <input type="checkbox"/> Yes <input type="checkbox"/> No Child has no discernible speech problem <input type="checkbox"/> Yes <input type="checkbox"/> No Speech evaluation recommended <input type="checkbox"/> Yes <input type="checkbox"/> No Child has possible problem with _____	<input type="checkbox"/> Date _____ Type <input type="checkbox"/> C <input type="checkbox"/> V    Results _____ µg/dL <input type="checkbox"/> Date _____ Type <input type="checkbox"/> C <input type="checkbox"/> V    Results _____ µg/dL <b>Tuberculin Test</b> 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 <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth /    /
----------------	--	-------------------------

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 /    /
-----------	------------	----------------

**TO BE COMPLETED  
BY DENTIST**

## 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)

<input type="checkbox"/> Examination	<input type="checkbox"/> Fluoride application	<input type="checkbox"/> Oral prophylaxis (cleaning)	<input type="checkbox"/> Prescription for fluoride supplement
<input type="checkbox"/> Orthodontic assessment	<input type="checkbox"/> Radiographs	<input type="checkbox"/> Dental sealant	<input type="checkbox"/> Treatment (restoration, pulp therapy)
<input type="checkbox"/> Other _____			

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

<input type="checkbox"/> Toothbrushing	<input type="checkbox"/> Flossing	<input type="checkbox"/> Dietary counseling	<input type="checkbox"/> Use of fluoride mouthrinse
<input type="checkbox"/> Other _____			

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

<input type="checkbox"/> All necessary preventive services have been performed. (Fluoride treatment, prophylaxis)
<input type="checkbox"/> No restorative services are required at this time.
<input type="checkbox"/> Further treatment is indicated.(See comments)
<input type="checkbox"/> Further appointments have been arranged. (Orthodontic, restorative)
<input type="checkbox"/> Routine recall visits recommended.

Comments

---



---



---



---

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