

Bradford Exempted Village Schools

School Health Services: Phone: (937) 448-2811 Fax (937) 448-2742

Welcome to 2017 Kindergarten Screening from the Nurse,

For many of you this may be your first experience with sending a child to school. Yet others may be experts by now. Either way, I want to make you aware of some changes related to immunization requirements and give you a list of all the **required health forms that must be completed** in order for your child to enter Kindergarten.

The Ohio Department of Health now requires all Kindergarteners to have a **second** Varicella (chicken pox) immunization along with the Dtap, MMR, and Polio **prior** to entering school. By law, any child not having the required immunizations will be excluded from school. Your child may get these injections at the Miami or Darke Co Health Department. You may also check with your pediatrician, your child may be able to get these immunizations during their **required physical**. Kindergarten physical appts. fill up very quickly. Please **call your physician NOW** to schedule an appt. in order to obtain your child's physical and required immunizations by August 1, 2017.

Included within:

- **Required Health Forms:** *part to be completed by parent, part by Physician*
 1. Health History form (completed by parent) **THIS FORM IS 2-SIDED**
 2. Physical Exam form (completed by Physician) **THIS FORM IS 2-SIDED**
 3. Immunization Report (or attach a copy of official immunization record)
 4. *Oral Assessment (completed by Dentist) not required but encouraged*

Please complete and **return** these forms ASAP or **by August 1st, 2017**.

Also, if your child has **any health related issues** such as food allergies, asthma, or diabetes or if he/she has any other **health concerns that may require daily medication administration, please contact me**, Moniqua Skinner RN, BSN, **yet this school year** at the school: 448-2811 ext. 1103.

Thank you for your cooperation in advance and I look forward to meeting with your child throughout the school year.

Sincerely,

Mrs. Skinner RN, BSN

Mrs. Moniqua Skinner, RN, BSN
Bradford EVSD Nurse

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 / /
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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?	<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"/> YES , my child receives regular medical/health care for the following conditions:		<input type="checkbox"/> NO 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.		School restrictions or recommended actions
Allergy type	Reaction	
<input type="checkbox"/> Bee/Insect		
<input type="checkbox"/> Food		
<input type="checkbox"/> Medication		
<input type="checkbox"/> Other		

To be completed by Parent

All pages of this Health History/Physical packet are to be turned in together no later than 8/1.

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 / /
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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	<input type="checkbox"/> Date _____ Type <input type="checkbox"/> C <input type="checkbox"/> V Results _____ µg/dL
Child has no discernible speech problem <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Date _____ Type <input type="checkbox"/> C <input type="checkbox"/> V Results _____ µg/dL
Speech evaluation recommended <input type="checkbox"/> Yes <input type="checkbox"/> 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 / /

<input type="checkbox"/> Essentially normal	<input type="checkbox"/> Abnormalities as follows

Is this child able to participate fully in:	
Classroom and academic activities <input type="checkbox"/> Yes <input type="checkbox"/> No	Physical education classes <input type="checkbox"/> Yes <input type="checkbox"/> No
Competition athletics <input type="checkbox"/> Yes <input type="checkbox"/> No	Contact and collision sports <input type="checkbox"/> Yes <input type="checkbox"/> 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 / /
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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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To be signed by Physician or attach a copy of official immunization record

Ohio Department of Health • School and Adolescent Health
Oral Assessment

Student's name	Date of birth / /
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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

To be completed by Dentist (assessment not required but encouraged)