

STUDENT NAME: _____ DOB: ____ / ____ / ____ GRADE: _____

REQUIRED FOR KINDERGARTEN OR FIRST GRADE STUDENTS

IMMUNIZATION INFORMATION

Complete using entire date as follows: mm/dd/yyyy

DTP, DT or DTaP	1. _____	2. _____	3. _____	4. _____	5. _____
Td or Tdap	1. _____	2. _____			
Polio IPV/OPV	1. _____	2. _____	3. _____	4. _____	5. _____
HIB	1. _____	2. _____	3. _____	4. _____	
Hepatitis B	1. _____	2. _____	3. _____		
MMR	1. _____	2. _____			
Varicella (vaccine)	1. _____	2. _____			
Meningococcal	1. _____	2. _____			
Other _____	_____	_____			

Immunization Exemption: Written statement required from parent/guardian or physician. (Ohio Revised Code, Section 3313.671)

EXAMINATION Date: _____ Height: _____ Weight: _____ Blood Pressure: _____

Findings: All normal or Indicate any **abnormal findings** below.

Remarks / Recommendations		Remarks / Recommendations	
<input type="checkbox"/> Posture _____	<input type="checkbox"/> Heart _____		
<input type="checkbox"/> Neck _____	<input type="checkbox"/> Lungs _____		
<input type="checkbox"/> Skin _____	<input type="checkbox"/> Abdomen _____		
<input type="checkbox"/> Nervous System _____	<input type="checkbox"/> Genitalia _____		
	<input type="checkbox"/> Hernia _____		

Restrictions: _____

Hearing Type of Test: _____ Results: _____ Comments: _____

Vision Acuity: Right – 20/ _____ Left – 20/ _____ Strabismus: Yes No Comments: _____

Dental General dental health: _____ Work indicated: Yes No

Chronic Health Concerns: Asthma Seizure Disorder ADD/ADHD Diabetes Other: _____

Comments: _____

<u>Medication</u>	<u>Dosage/Frequency</u>	<u>Reason</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Indicate if child was referred to a specialist for any reason (explain): _____

Special Tests (physician's discretion)

Urinalysis _____ Hematocrit _____ Lead _____ Sickle Cell _____

Tuberculin Test Date: _____ Type: _____ Results : Positive Negative

Physician Information (Print/Type)

Name _____
Address _____
City/State/Zip _____
Phone _____

Based on examination consistent with EPSDT/Headstart/AAP guidelines, I certify this child to be in suitable condition for enrollment in school.

Signature: _____

_____/_____/_____
DATE

PHYSICIAN SIGNATURE

DATE