



HEALTH FORM

If you have any questions regarding this form, please call the school nurse at 216-581-1644, extension 5011.

Student's Name: _____ Date of Birth: _____

Part 1: IMMUNIZATIONS [to be completed by the parent/guardian]

In order to attend school, your son/daughter must have completed the following immunizations which are required by the Ohio Department of Health.

- *Minimum compliance consists of four (4) doses of DTP or DT vaccine or any combination thereof. A student who is 7 years or older and received a Td or Tdap vaccine as the third part of the immunization series shall not be required to receive further doses of diphtheria tetanus, or pertussis.*
- *Four (4) doses of the Polio vaccine if a combination of OPV or IPV was administered. Four (4) doses of all OPV or all IPV is required if the third dose of either vaccine was administered prior to the fourth birthday.*
- *Two (2) doses of Measles, Mumps, Rubella (can be separate or MMR). The first dose must have been received on or after the first birthday. The second dose must be at least 28 days after the first.*
- *Three (3) doses of Hepatitis B are required for the Class of 2012 and above. The second dose must be at least four weeks from the first dose. The third dose must be at least eight weeks from the second and at least 16 weeks from the first dose. The last dose cannot be given before 24 weeks of age.*
- *A Tuberculin skin test to determine if the student has been exposed to Tuberculosis is highly recommended.*

According to regulations of the Ohio Department of Health, on the **15th day after school begins**, it will be necessary to exclude all pupils from school who do not meet the above requirements.

	Dates of Immunizations (mm/dd/yy)					
	1	2	3	4	5	6
DPT (include DT & Tetanus shots)						
POLIO					NOTE: Month, day, and year of all immunizations are required.	
MEASLES	1 (after 1 year old)		2			
RUBELLA	1 (after 1 year old)		2			
MUMPS or MMR	1 (after 1 year old)		2			
	1 (after 1 year old)		2			
HIB	1	2	3	4		
HEPATITIS B	1	2	3			
TUBERCULIN Test	1	Type:	Results:			
Others	Name of Immunization:				Date:	
	Name of Immunization:				Date:	

Part 2: HISTORY [to be completed by the parent/guardian]

Chicken Pox (date): _____ Vaccine received: _____

Asthma (include medications being used): _____

Directives to be followed if attack occurs: _____

Bee Sting Allergy: _____ Local: _____ Severe: _____ Symptoms: _____

Directives to be followed if stung: _____

Other conditions, medications being taken, etc.: _____

Part 3: EXAMINATION BY PHYSICIAN [to be completed by your physician]

For the safety and well-being of your child, we recommend a current physical.

If your child will play a school sport, please attach a copy of the completed Ohio High School Athletic Association (OHSAA) Physical Form.

Date of exam: _____

Blood Pressure: _____ Height: _____ Weight: _____

Vision: (right) 20/____ (left) 20/____ Hearing test: Type _____ R: _____ L: _____

Throat: _____ Glands, Neck: _____

Teeth: _____ Is referral for dental work needed?: _____

Posture: _____ Orthopedic: _____

Skin: _____ Heart: _____

Lungs: _____ Abdomen: _____

General condition: _____

Existing medical conditions: _____

Medications being taken: _____

Restrictions: _____

Signature of Physician: _____ Date: _____