TRINITY

AN EDUCATIONAL MINISTRY OF THE SISTERS OF ST. JOSEPH OF THE THIRD ORDER OF ST. FRANCIS

HEALTH FORM

If you have any questions regarding this form, please call the school health aide at 216-581-5771.

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.

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 immunization requirements.

	Dates of Immunizations (mm/dd/yy)					
DTaP/DT/Tdap/Td (Diphtheria, Tetanus, Pertussis) *Please list dates and note type. One Tdap required prior to entering 7th grade.*	1	2	3	4	5	Tdap date:
POLIO *3 or more required. If 3rd dose received before 4th birthday, 4th dose required. If a combination of OVP and IVP was administered, 4 doses required.*	1	2	3	4	**NOTE:** Please list month, day, and year (mm/dd/yy) for all immunizations the child has received or attach immunization record from doctor's office.	
MMR (Measles, Mumps, Rubella) *Two required*	1		2			
HEP B (Hepatitis B) *Three required*	1	2	3			
VAR (Varicella/Chickenpox) *One dose required on or after the first birthday.*	1					
MCV4 (Meningococcal) *Two doses required prior to entry into 12th grade.*	1		2			
Hib (H. Influenzae Type B) ***RECOMMENDED, but Not Required.***	1	2	3	4	5	6
Others	Name of Immunization:				Date:	
	Name of Immunization:				Date:	

Part 2: 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, which can be found at http://www.ohsaa.org/medicine/physicalform.htm.

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: ____________________

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Existing medical conditions: ____________________

____

Medications being taken: ____________________

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Restrictions: ____________________

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Signature of Physician: ____________________ Date: ____________