



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) <i>Please list dates and note type. One Tdap required prior to entering 7th grade.</i>	1	2	3	4	5	Tdap date:
POLIO <i>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.</i>	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) <i>Two required</i>	1		2			
HEP B (Hepatitis B) <i>Three required</i>	1	2	3			
VAR (Varicella/Chickenpox) <i>One dose required on or after the first birthday.</i>	1					
MCV4 (Meningococcal) <i>Two doses required prior to entry into 12th grade.</i>	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://ohsaa.org/medicine/physicalexamform>.

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: _____