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: _____

Entry Grade Level: _____

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.

A printed immunization record from your doctor's office may be submitted in place of this form.

	Dates of Immunizations (mm/dd/yy)					
DTaP/DT/Tdap/Td (Diphtheria, Tetanus, Pertussis) *Please list dates and note type. One Tdap required on or after tenth birthday.*	1	2	3	4	5	Tdap date:
IPV (Polio) *THREE or more required. Final dose must be administered on or after fourth birthday.*	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) *TWO required*	1		2			
MCV4 (Meningococcal) *TWO doses (by age 16) required prior to entry into Grade 12.*	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:	

– Over for Part 2: Examination by Physician –

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: _____