THE TROY SCHOOLS
KINDERGARTEN SCHOOL HEALTH EXAMINATION RECORD

PARENT FORM – PART I

DEAR PARENT:

Troy School entrance requirements: Birth certificate and immunizations as required by Ohio State Law and health examination.

For the welfare of your child, will you please see that the health requirements are met? Please complete Part I and have your family physician complete Part II. THIS IS A PREREQUISITE FOR SCHOOL ADMISSION.

TODAY’S DATE:

<table>
<thead>
<tr>
<th>CHILD’S NAME (Last, First, Middle)</th>
<th>BIRTHDATE</th>
<th>HOME ADDRESS (Number, Street, City, Zip)</th>
<th>RESIDENCE PHONE</th>
</tr>
</thead>
<tbody>
<tr>
<td>FATHER’S or GUARDIAN’S NAME</td>
<td>PLACE OF EMPLOYMENT</td>
<td>BUSINESS PHONE</td>
<td></td>
</tr>
<tr>
<td>MOTHER’S or GUARDIAN’S NAME</td>
<td>PLACE OF EMPLOYMENT</td>
<td>BUSINESS PHONE</td>
<td></td>
</tr>
<tr>
<td>PHYSICIAN’S NAME</td>
<td>ADDRESS</td>
<td>OFFICE PHONE</td>
<td></td>
</tr>
</tbody>
</table>

Is there anything about your child that the teacher needs to know to understand him/her better?

Is your child taking any prescribed medication? Is so, specify here:

List diseases and other serious illnesses, injuries or health conditions your child has had:

- Chicken Pox: No ( ) Yes ( )
- Nut Allergies: No ( ) Yes ( )
- Bee Allergies: No ( ) Yes ( )
- Seizures: No ( ) Yes ( )
- Glasses: No ( ) Yes ( )
- Hearing Aid: No ( ) Yes ( )

Operations:

Physical handicap:

Other (please specify):

APPROVED MEANS OF IMMUNIZATION
AS REQUIRED BY SECTIONS 3701.13, 3313.671 OF THE OHIO REVISED CODE
Effective August 15, 2010

Pupils enrolled in kindergarten through grade 12 are required to have written proof on file at their public or nonpublic school that they have been immunized against diphtheria, tetanus, pertussis, poliomyelitis, measles, mumps, rubella, hepatitis B, and Varicella (chickenpox) as set forth in Section 3313.671 of the Ohio Revised Code. Pupils who have not been immunized by “a method of immunization approved by the Department of Health pursuant to Section 3701.13 of the Revised Code,” are to be excluded from school attendance no later than fifteen school days after admission.
THE TROY SCHOOLS  
SCHOOL HEALTH EXAMINATION RECORD  
PHYSICIAN FORM – PART II  

STUDENT NAME: ______________________________________________________  
DATE OF BIRTH: ____________________________  

TO BE COMPLETED BY PHYSICIAN: (Or Attach Copy of Immunization Record)  

<table>
<thead>
<tr>
<th>IMMUNIZATIONS</th>
<th>Date #1</th>
<th>Date #2</th>
<th>Date #3</th>
<th>Date #4</th>
<th>Date #5</th>
</tr>
</thead>
<tbody>
<tr>
<td>DTap</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>POLIO</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MMR (Measles, mumps, rubella)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIB-V</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HEPATITIS-B</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>VARICELLA (Chicken Pox) (2)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OTHER</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

PHYSICAL EXAMINATION: To be filled in and signed by physician:  

Date: ____________  Age: ____________  Height: _______________  Weight: _______________

GENERAL APPEARANCE, NUTRITIONAL STATE  

Posture ____________________________________________________________  
Skin ______________________________________________________________  
Eyes ________________________________________________________________  
Ears ________________________________________________________________  
Nose ________________________________________________________________  
Throat (tonsils) _____________________________________________________  
Mouth (teeth, etc.) _________________________________________________  
Neck _______________________________________________________________  
Heart _______________________________________________________________  
Blood Pressure _____________________________________________________  
Lungs _________________________________________________________________  
Abdomen _____________________________________________________________  
Genitalia _____________________________________________________________  
Hernia ________________________________________________________________  
Neurological ___________________________________________________________  
Emotional _____________________________________________________________  

May carry full Physical Education Program?  Restricted Physical Education Program?  Explain:  

Special Tests (at doctor’s discretion)  

Urinalysis ___________________________________________________________  
Hemoglobin ___________________________________________________________  
Tuberculin _____________________________________________________________  
Other ________________________________________________________________  

What medication, if any, is the child taking?  

Physicians Report of Health Findings:  

[ ] Entirely within normal limits  
[ ] Abnormalities as follows:  

Recommendations for adjustment in school program, including participation in sports activities:  

Date: _________________________  
Signature of Examining Physician:  

Typed or Printed Name of Examining Physician:  

Rev. 1.10  
PS06