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:

CHILD'S NAME (Last, First, Middle)	BIRTHDATE	HOME ADDRESS (Number, Street, City, Zip)	RESIDENCE PHONE

FATHER'S or GUARDIAN'S NAME	PLACE OF EMPLOYMENT	BUSINESS PHONE
MOTHER'S or GUARDIAN'S NAME	PLACE OF EMPLOYMENT	BUSINESS PHONE
PHYSICIAN'S NAME	ADDRESS	OFFICE PHONE

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 ( )	Operations:
Nut Allergies	No ( )	Yes ( )	
Bee Allergies	No ( )	Yes ( )	
Seizures	No ( )	Yes ( )	Physical handicap:
Glasses	No ( )	Yes ( )	
Hearing Aid	No ( )	Yes ( )	
			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)

IMMUNIZATIONS					
	Date #1	Date #2	Date #3	Date #4	Date #5
DTap					
DT					
POLIO					
MMR (Measles, mumps, rubella)					
HIB-V					
HEPATITIS-B					
VARICELLA (Chicken Pox) (2)					
OTHER					

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

Date: _____ **Age:** _____ **Height:** _____ **Weight:** _____

GENERAL APPEARANCE, NUTRITIONAL STATE	**REMARKS CONCERNING ANY ABNORMAL FINDINGS:**
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