To: Parents of Children Entering Kindergarten/ Parents of Transfer Students

From: *School Health Clinic*

Subject: *Required Health Forms*

The following forms are required for school entrance:

Health History Form to be completed by parent/guardian.

Physical Exam Form to be completed by physician/health care provider. The exam must be current (within one year).
DUE NO LATER THAN THE FIRST DAY OF SCHOOL

Record of Immunization Form to be completed by physician. A copy from the physician's office is also acceptable
DUE NO LATER THAN THE FIRST DAY OF SCHOOL

Ohio Department of Health

Ohio Immunization Summary for School Attendance

VACCINES	FALL 2022 Immunizations for School Attendance
DTaP/DT Tdap/Td Diphtheria, Tetanus, Pertussis	**K-12** Four or more doses of DTaP or DT, or any combination. If all four doses were given *before the fourth birthday*, a fifth dose is *required.* If the fourth dose was administered at least six months after the third dose, and on or after the fourth birthday, a fifth dose is not required.* **Grades 1-12** Three doses of Td or a combination of Td and Tdap is the minimum acceptable for children ages 7 years and older with the first dose being Tdap. Minimum spacing of four weeks between doses 1 and 2, and six months between doses 2 and 3. **Grade 7** One dose of Tdap vaccine must be administered on or after the 10th birthday. ** ***All students in grades 8-12 must have one documented Tdap dose.***
POLIO	**K-12** Three or more doses of IPV. *The FINAL dose must be administered on or after the fourth birthday,* regardless of the number of previous doses ***and*** *there must be six months spacing between doses 2 and 3.* If a combination of OPV and IPV was received, four doses of either vaccine are required.
MMR Measles, Mumps, Rubella	**K-12** Two doses of MMR. The first dose must be administered on or after the first birthday. The second dose must be administered at least 28 days after the first dose.
HEP B Hepatitis B	**K-12** Three doses of hepatitis B. The second dose must be administered at least 28 days after the first dose. The third dose must be given at least 16 weeks after the first dose and at least eight weeks after the second dose. The last dose in the series (third or fourth dose) must not be administered before age 24 weeks.
VARICELLA (Chickenpox)	**K-12** Two doses of varicella vaccine must be administered prior to entry. The first dose must be administered on or after the first birthday. The second dose should be administered at least three months after the first dose; however, if the second dose is administered at least 28 days after the first dose, it is considered valid.
MCV4 Meningococcal	**Grade 7** One dose of meningococcal (serogroup A, C, W, and Y) vaccine must be administered prior to seventh grade entry. **All students grades 8-11 must have one documented dose of MCV4.** **Grade 12** Two doses of MCV4 by age 16 years, with a minimum interval of eight weeks between doses. If the first dose was given on or after the 16th birthday, only one dose is required. ****

NOTES:

- Vaccine should be administered according to the most recent version of the *Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger* or the *Catch-up immunization schedule for persons aged 4 months-18 years who start late or who are more than 1 month behind,* as published by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices. Schedules are available for print or download through www.cdc.gov/vaccines/schedules/index.html.
- Vaccine doses administered less than or equal to four days before the minimum interval or age are valid (grace period). Doses administered greater than or equal to five days earlier than the minimum interval or age are not valid doses and should be repeated when age appropriate. If MMR and varicella are **not** given on the same day, the doses must be separated by at least 28 days with no grace period.
- For additional information, please refer to the Ohio Revised Code 3313.67 and 3313.671 for school attendance and the ODH Director's Journal Entry on required vaccines for child care and school. These documents list required and recommended immunizations and indicate exemptions to immunizations.
- **Please contact the Ohio Department of Health Immunization Program at 800-282-0546 or 614-466-4643 with questions or concerns.**

** Recommended DTaP or DT minimum intervals for kindergarten students are four weeks between the first and second doses, and the second and third doses; and six months between the third and fourth doses and the fourth and fifth doses. If a fifth dose is administered prior to the fourth birthday, a sixth dose is recommended but not required.*

*** Tdap can be given regardless of the interval since the last tetanus or diphtheria-toxoid containing vaccine. Children age 7 years or older with an incomplete history of DTaP should be given Tdap as the first dose in the catch-up series. If the series began at age 7-9 years, the fourth dose must be a Tdap given at age 11-12 years. If the third dose of Tdap is given at age 10 years, no additional dose is needed at age 11-12 years.*

**** The final polio dose in the IPV series must be administered at age 4 years or older with at least six months between the final and previous dose.*

***** Recommended MCV4 minimum interval of at least eight weeks between the first and second doses. If the first dose of MCV4 was administered on or after the 16th birthday, a second dose is not required. If a pupil is in 12th grade and is 15 years old or younger, only one dose is required. Currently, there are no school entry requirements for meningococcal B vaccine.*

Last updated 12/01/2021.

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Physical Examination

Student's name	Sex ☐ Male ☐ Female	Date of birth / /

Height	Weight	BMI percentile	BP

Screening Tests

Vision

Date performed / /

Distance Acuity	☐ R	☐ L
Muscle Balance	☐ Pass	☐ Fail
Stereopsis	☐ Pass	☐ Fail
Color	☐ Pass	☐ Fail
Child wears glasses?	☐ Yes	☐ No
Tested with glasses?	☐ Yes	☐ No
Referral made?	☐ Yes	☐ No

Hearing

Date performed / /

Pure Tone		
Right ear	☐ Pass	☐ Fail
Left ear	☐ Pass	☐ Fail
Child wears hearing aid?	☐ Yes	☐ No
Child under the care of a hearing specialist	☐ Yes	☐ No
Referral made?	☐ Yes	☐ No

Postural

Date performed / /

☐ No abnormality noted
☐ Screening not done
☐ Referral made
Comments
_____
_____
_____

Speech/Language

Speech assessment completed	☐ Yes	☐ No
Child has no discernible speech problem	☐ Yes	☐ No
Speech evaluation recommended	☐ Yes	☐ No

Child has possible problem with _____

Lead Poisoning

☐ Date _____ Type ☐ C ☐ V Results_____ µg/dL
☐ Date _____ Type ☐ C ☐ V Results_____ µg/dL

Tuberculin Test

Date_____ Type _____ Results_____

Health History (Serious or chronic illnesses/injuries/surgeries)

_____

Physical Examination Date of most recent examination / /

☐ Essentially normal ☐ Abnormalities as follows

_____

_____

Is this child able to participate fully in:

Classroom and academic activities	☐ Yes	☐ No	Physical education classes	☐ Yes	☐ No
Competition athletics	☐ Yes	☐ No	Contact and collision sports	☐ Yes	☐ No

If limitations are advised, please specify

_____

_____

Does this child have any physical, developmental or behavioral issues that may affect his/her educational process?

_____

_____

HealthCare Provider's signature	Print name	Phone ( )
Address		Date / /
City	State	ZIP

HEA 4242 8/06

Ohio Department of Health • School and Adolescent Health

Health History

Student's name	Sex	Date of birth
	☐ Male ☐ Female	/ /

Family Health History Please list allergies, heart problems, diabetes, cancer or other serious health conditions.

Father
Mother
Brothers and Sisters

Birth and Developmental History ☐ No unusual birth or developmental history

Did the mother have any unusual physical or emotional illness during this pregnancy? ☐ Yes ☐ No

Was infant born full term? ☐ Yes ☐ No Did the infant have any sickness or problems? ☐ Yes ☐ No

Briefly explain illness or problems.

How does the child's development compare to other children, such as his or her brothers/sisters or playmates?

☐ About the same ☐ Delayed ☐ Advanced

Student Health Conditions

☐ **YES,** my child receives regular medical/health care for the following conditions: ☐ **NO** medical conditions

☐ Allergies	☐ Diabetes	☐ Seizure disorder
☐ Asthma	☐ Depression	☐ Sickle cell anemia
☐ ADD/ADHD	☐ Ear problem/hearing difficulty	☐ Skin conditions
☐ Autism	☐ Emotional concerns	☐ Speech problems
☐ Behavior concerns	☐ Headaches	☐ Traumatic brain injury
☐ Birth/congenital malformations	☐ Heart problems	☐ Vision problems (glasses, contacts)
☐ Bone/muscle/joint problems	☐ Hemophilia	☐ Other_____
☐ Blood problems	☐ Juvenile arthritis	☐ Other_____
☐ Bowel/bladder problems	☐ Lead poisoning	☐ Other_____
☐ Cancer	☐ Migraines	☐ Other_____
☐ Cystic fibrosis	☐ Neuromuscular disorder	☐ Other_____

Please explain any conditions above or any reasons for hospitalizations.

Please indicate any allergies your child may have.

Allergy type	Reaction	School restrictions or recommended actions
☐ Bee/Insect		
☐ Food		
☐ Medication		
☐ Other		

Health History continued

Please list any prescription and over the counter medication that your child takes on a regular basis.

Medication and dose	Time	Reason

Do any health and/or medical conditions require school restrictions, modifications, and/or intervention?

☐ Yes ☐ No If YES, please explain.

Does the student require any special procedures and/or treatments for their health condition(s)?

☐ Yes ☐ No If YES, please explain.

Please indicate any other information about your child's health or development that you think would be helpful for the school to know.

Form completed by	Relationship to student	Date
		/ /

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Immunization Report

Student's name	Sex	Date of birth
	☐ Male ☐ Female	/ /

Students are required to be immunized in accordance with Ohio law (Ohio Revised Code 3313.67/3313.671).
A copy of the child's immunization record may be attached or dates may be entered below.
Please note the month, day, and year for each immunization should be on record.

Vaccine	**Record complete dates** (month, day, year) **of vaccine doses given**					
Diphtheria, Tetanus, Pertussis (DTP)						
DTaP, Tdap						
DT, Td						
Polio						
Hepatitis B (HBV)						
Measles, Mumps, Rubella (MMR)						
Varicella (Chickenpox)						
Hepatitis A						
Meningococcal (MCV4, MPSV4)						
Pneumococcal (PCV)						
Measles (Rubeola) only						
Rubella only						
Mumps only						
Haemophilus influenza Type b (Hib)						
Influenza						
Other						

This information was provided by ☐ Health Care Provider ☐ Parent/Guardian ☐ Other _____

Signature	Print name	Date
		/ /

HEA 4241 8/06

Ohio Department of Health

Authorization to Disclose Immunization Information

Name of Child _____ Date of Birth _____

I, _____, as the parent of guardian of the above named child, hereby authorize (*Name of Provider[s])*

_____

_____
to disclose the specific and individually identifiable immunization records of the above named child to (*Name of School)*:

_____
for the specific purpose of presenting written evidence, satisfactory to the person in charge of admission, that the above named child has been immunized by a method of immunization approved by the department of health as required by section 3313.671 of the Ohio Revised Code.

This authorization will expire upon the presentation of written evidence sufficient to comply with section 3313.671 of the Ohio Revised Code or for the period of time needed to fulfill its purpose. I also understand that I may revoke this authorization, in writing, at any time and that I may be asked to sign the *Revocation Section* on the back of this form. I further understand that any action taken by the above named Provider(s) or School in accordance to this authorization prior to it being revoked is legal and binding.

I understand that my information may not be protected from re-disclosure by the requester of the information unless otherwise provided for by state or federal law. Please note: medical records provided to schools that receive federal funding are protected by the Family Educational Rights and Privacy Act (FERPA).

I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given.

I also understand that my refusal to sign this authorization may prevent the school from verifying that the above named child has been immunized. I further understand that if the school cannot verify and I cannot provide satisfactory written evidence that the above named child has been immunized, the child may be excluded from school pursuant to section 3313.671 of the Ohio Revised Code.

I further understand that I may request a copy of this signed authorization.

_____	_____	_____
(Signature of Personal Representative)	*(Date)*	*(Relationship / Authority)*

****

NOTE: This Authorization was revoked on:	_____	_____
	(Date)	*(Signature of Staff)*

Last reviewed: December 2014