

## Greenville Elementary

Greenville City Schools

1111 N. Ohio St.

Greenville, Ohio 45331

(937) 548-1013 phone

(937) 548-2175 fax

Spring 2020

Dear Parent or Guardian:

The Greenville Board of Education requires physical examinations and complete immunizations for all students entering kindergarten, and any student entering first grade (if the child did not previously attend kindergarten at Greenville City Schools). A dental examination is strongly recommended. You may use the attached form.

### **The School Health Examination Record and Immunization**

**Record must be returned by Monday, August 3, 2020.** Please take forms to Greenville Elementary or mail forms to Greenville Elementary at above address. **Do NOT take form to Memorial Hall.** Please be sure your child's name and birth date are on the physical and dental forms.

Sections 3313.671 and 37101.13 of the Ohio Revised Code require that all pupils must **present written evidence (exact dates)** of having received, or are in the process of receiving, immunizations as required by the State of Ohio to enter kindergarten. The following are the requirements for all kindergarten students:

<b>Immunization</b>	<b>Required Dose</b>
DTaP/DTP/DT/Td	5 doses
Polio	4 doses
MMR	2 doses
Hep B	3 doses
Varicella (chicken pox)	2 doses

If there is a medical reason why immunizations cannot be obtained, it must be reported in writing by the family physician. Objection on religious grounds is a valid exemption only when a written statement to this effect is signed by a parent or guardian.

The Darke County Health Department will provide immunizations on Tuesdays from 8:00 AM to 10:30 AM and 2:00 PM to 5 PM. The Darke County Health Department is located at 300 Garst Avenue, Greenville, Ohio. The telephone is 548-4196. It is a "walk in clinic", no appointment is necessary.

Sincerely,

Beth Shellhaas, RN, BSN, CSN  
School Nurse

# Ohio Department of Health • School and Adolescent Health

## Health History

Student's name	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth /    /
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**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? <input type="checkbox"/> Yes <input type="checkbox"/> No
Was infant born full term? <input type="checkbox"/> Yes <input type="checkbox"/> No      Did the infant have any sickness or problems? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> About the same <input type="checkbox"/> Delayed <input type="checkbox"/> Advanced

**Student Health Conditions**

<input type="checkbox"/> <b>YES</b> , my child receives regular medical/health care for the following conditions: <input type="checkbox"/> <b>NO</b> medical conditions		
<input type="checkbox"/> Allergies	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Seizure disorder
<input type="checkbox"/> Asthma	<input type="checkbox"/> Depression	<input type="checkbox"/> Sickle cell anemia
<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Ear problem/hearing difficulty	<input type="checkbox"/> Skin conditions
<input type="checkbox"/> Autism	<input type="checkbox"/> Emotional concerns	<input type="checkbox"/> Speech problems
<input type="checkbox"/> Behavior concerns	<input type="checkbox"/> Headaches	<input type="checkbox"/> Traumatic brain injury
<input type="checkbox"/> Birth/congenital malformations	<input type="checkbox"/> Heart problems	<input type="checkbox"/> Vision problems (glasses, contacts)
<input type="checkbox"/> Bone/muscle/joint problems	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Other _____
<input type="checkbox"/> Blood problems	<input type="checkbox"/> Juvenile arthritis	<input type="checkbox"/> Other _____
<input type="checkbox"/> Bowel/bladder problems	<input type="checkbox"/> Lead poisoning	<input type="checkbox"/> Other _____
<input type="checkbox"/> Cancer	<input type="checkbox"/> Migraines	<input type="checkbox"/> Other _____
<input type="checkbox"/> Cystic fibrosis	<input type="checkbox"/> Neuromuscular disorder	<input type="checkbox"/> 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
<input type="checkbox"/> Bee/Insect		
<input type="checkbox"/> Food		
<input type="checkbox"/> Medication		
<input type="checkbox"/> 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.

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Form completed by	Relationship to student	Date / /
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Ohio Department of Health • School and Adolescent Health

# Physical Examination

Student's name		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of birth / /
Height	Weight	BMI percentile	BP	

### Screening Tests

Vision	Hearing	Postural
Date performed / /	Date performed / /	Date performed / /
Distance Acuity <input type="checkbox"/> R <input type="checkbox"/> L Muscle Balance <input type="checkbox"/> Pass <input type="checkbox"/> Fail Stereopsis <input type="checkbox"/> Pass <input type="checkbox"/> Fail Color <input type="checkbox"/> Pass <input type="checkbox"/> Fail Child wears glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No Tested with glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No Referral made? <input type="checkbox"/> Yes <input type="checkbox"/> No	Pure Tone Right ear <input type="checkbox"/> Pass <input type="checkbox"/> Fail Left ear <input type="checkbox"/> Pass <input type="checkbox"/> Fail Child wears hearing aid? <input type="checkbox"/> Yes <input type="checkbox"/> No Child under the care of a hearing specialist <input type="checkbox"/> Yes <input type="checkbox"/> No Referral made? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> No abnormality noted <input type="checkbox"/> Screening not done <input type="checkbox"/> Referral made Comments _____ _____ _____

Speech/Language	Lead Poisoning
Speech assessment completed <input type="checkbox"/> Yes <input type="checkbox"/> No Child has no discernible speech problem <input type="checkbox"/> Yes <input type="checkbox"/> No Speech evaluation recommended <input type="checkbox"/> Yes <input type="checkbox"/> No Child has possible problem with _____	<input type="checkbox"/> Date _____ Type <input type="checkbox"/> C <input type="checkbox"/> V Results _____ µg/dL <input type="checkbox"/> Date _____ Type <input type="checkbox"/> C <input type="checkbox"/> V Results _____ µg/dL <b>Tuberculin Test</b> Date _____ Type _____ Results _____

### Allergies (Food, Medicine, Environmental):

Allergy to:	Reaction:	Is food substitution needed: Yes / No
_____	_____	_____
_____	_____	_____

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

_____
_____

### Physical Examination Date of most recent examination / /

<input type="checkbox"/> Essentially normal	<input type="checkbox"/> Abnormalities as follows
_____	
_____	
Is this child able to participate fully in:	
Classroom and academic activities <input type="checkbox"/> Yes <input type="checkbox"/> No	Physical education classes <input type="checkbox"/> Yes <input type="checkbox"/> No
Competition athletics <input type="checkbox"/> Yes <input type="checkbox"/> No	Contact and collision sports <input type="checkbox"/> Yes <input type="checkbox"/> 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



## Ohio Department of Health • School and Adolescent Health

# Oral Assessment

Student's name	Date of birth / /
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**The following services have been performed** (please check all that apply)

<input type="checkbox"/> Examination	<input type="checkbox"/> Fluoride application	<input type="checkbox"/> Oral prophylaxis (cleaning)	<input type="checkbox"/> Prescription for fluoride supplement
<input type="checkbox"/> Orthodontic assessment	<input type="checkbox"/> Radiographs	<input type="checkbox"/> Dental sealant	<input type="checkbox"/> Treatment (restoration, pulp therapy)
<input type="checkbox"/> Other _____			

**The following oral hygiene instruction was provided** (please check all that apply)

<input type="checkbox"/> Toothbrushing	<input type="checkbox"/> Flossing	<input type="checkbox"/> Dietary counseling	<input type="checkbox"/> Use of fluoride mouthrinse
<input type="checkbox"/> Other _____			

**The following statements are applicable** (please check all that apply)

<input type="checkbox"/> All necessary preventive services have been performed. (Fluoride treatment, prophylaxis)
<input type="checkbox"/> No restorative services are required at this time.
<input type="checkbox"/> Further treatment is indicated.(See comments)
<input type="checkbox"/> Further appointments have been arranged. (Orthodontic, restorative)
<input type="checkbox"/> Routine recall visits recommended.

Comments

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