REQUIREMENTS FOR ENTRANCE

- Physical examination by a licensed health care provider within twelve months before the start of the school year.
- Dental examination within 6 months before the start of school year.
- Health history competed by the parent/guardian.
- Compliance with the following immunizations as required by the Ohio Revised Code or completed exemption for religious of philosophical reasons.

Tuberculin TB	Physician recommendation only
DtaP/DT Tdap/TD	4 doses, a fifth dose is required if the fourth dose was given before the 4th birthday
Poliomeylitis OPV/IPV	3 or 4 doses, final dose must be administered on or after the 4th birthday
Varicella (chickenpox)	2 doses before the first day of kindergarten. The 1st dose must be given on or after the 1st birthday.
Measles/Mumps/Rubella MMR	2 doses-first dose given on or after 1st birthday, 2nd dose at least 28 days after, and before kindergarten
Hepatitis B	3 doses before the first day of kindergarten. The 2nd dose must be administered at least 28 days after the 1st dose. 3rd dose must be given at least 16 weeks after the 1st dose and 8 weeks after the 2nd dose. The last dose must not be administered before 24 weeks of age.

RETURN HEALTH RECORDS TO THE SCHOOL OFFICE BEFORE THE FIRST DAY OF SCHOOL
St. Andrew-St. Elizabeth Ann Seton School
5900 Buckwheat Road
Milford, Ohio 45150

If the above Ohio Department of Health and Department of Education requirements are not met by the 14TH day of school, the student will be excluded until proof of completion.

Please contact the school nurse powderlya@saseas.org 513-575-0093 ext. 6 for any immunization or health concerns.

Immunization Summary for School Attendance - Ohio

VACCINES	*FALL 2019* IMMUNIZATIONS FOR SCHOOL ATTENDANCE
DTaP/DT **Tdap/Td** Diphtheria, Tetanus, Pertussis	**Kindergarten** Four (4) or more doses of DTaP or DT, or any combination. If all four doses were given before the 4th birthday, a fifth (5) dose is required. If the fourth dose was administered at least six months after the third dose, and on or after the 4th birthday, a fifth (5) dose is not required. * **1-12** Four (4) or more doses of DTaP or DT, or any combination. Three doses of Td or a combination of Td and Tdap is the minimum acceptable for children age seven (7) and up. **Grades 7-12** One (1) dose of Tdap vaccine must be administered prior to entry. **
POLIO	**K-9** Three (3) or more doses of IPV. The FINAL dose must be administered on or after the 4th birthday regardless of the number of previous doses. If a combination of OPV and IPV was received, four (4) doses of either vaccine are required. *** **Grades 10-12** Three (3) or more doses of IPV or OPV. If the third dose of either series was received prior to the fourth birthday, a fourth (4) dose is required; If a combination of OPV and IPV was received, four (4) doses of either vaccine are required.
MMR Measles, Mumps, Rubella	**K-12** Two (2) doses of MMR. Dose one (1) must be administered on or after the first birthday. The second dose must be administered at least 28 days after dose one (1).
HEP B Hepatitis B	**K-12** Three (3) 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 8 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-9** Two (2) doses of varicella vaccine must be administered prior to entry. Dose one (1) must be administered on or after the first birthday. The second dose should be administered at least three (3) months after dose one (1); however, if the second dose is administered at least 28 days after the first dose, it is considered valid. **Grades 10-12** One (1) dose of varicella vaccine must be administered on or after the first birthday.
MCV4 Meningococcal	**Grades 7-10** One (1) dose of meningococcal (serogroup A, C, W, and Y) vaccine must be administered prior to entry. **Grade 12** Two (2) doses of meningococcal (serogroup A, C, W, and Y) vaccine must be administered prior to entry. ****

NOTES:

- Vaccine should be administered according to the most recent version of the *Recommended Immunization Schedule for Children and Adolescents Aged 18 Years or Younger* or the *Catch-up Immunization Schedule for Persons Aged 4 Months Through 18 Years Who Start Late or Who Are More Than 1 Month Behind*, as published by the Advisory Committee on Immunization Practices. Schedules are available for print or download at https://www.cdc.gov/vaccines/schedules/index.html.
- Vaccine doses administered ≤ 4 days before the minimum interval or age are valid (grace period). Doses administered ≥ 5 days earlier than the minimum interval or age are not valid doses and should be repeated as 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 (available at https://odh.ohio.gov/wps/portal/gov/odh/know-our-programs/Immunization/Required-Vaccines-Child-Care-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 four (4) weeks between doses 1-2 and 2-3; six (6) month minimum intervals between doses 3-4 and 4-5. If a fifth dose is administered prior to the 4th birthday, a sixth dose is recommended but not required.

** Pupils who received one dose of Tdap as part of the initial series are not required to receive another dose. Tdap can be given regardless of the interval since the last Tetanus or diphtheria-toxoid containing vaccine. DTaP given to patients age 7 or older can be counted as valid for the one-time Tdap dose.

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

**** Recommended MCV4 minimum interval of at least eight (8) weeks between dose one (1) and dose two (2). If the first (1st) dose of MCV4 was administered on or after the 16th birthday, a second (2nd) dose is not required. If a pupil is in 12th grade and is 15 years of age or younger, only 1 dose is required. Currently there are no school entry requirements for meningococcal B vaccine.

Ohio Department of Health • School and Adolescent Health

Physical Examination

PLEASE ATTACH A COPY OF IMMUNIZATION RECORD

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

PHYSCIAN COMPLETES-Physical must be completed within 12 months of start date of school

Ohio Department of Health • School and Adolescent Health

Oral Assessment

Student's name	Date of birth / /

The following services have been performed (please check all that apply)

☐ Examination ☐ Fluoride application ☐ Oral prophylaxis (cleaning) ☐ Prescription for fluoride supplement

☐ Orthodontic assessment ☐ Radiographs ☐ Dental sealant ☐ Treatment (restoration, pulp therapy)

☐ Other______________________________

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

☐ Toothbrushing ☐ Flossing ☐ Dietary counseling ☐ Use of fluoride mouthrinse

☐ Other______________________________

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

☐ All necessary preventive services have been performed. (Fluoride treatment, prophylaxis)

☐ No restorative services are required at this time.

☐ Further treatment is indicated.(See comments)

☐ Further appointments have been arranged. (Orthodontic, restorative)

☐ Routine recall visits recommended.

Comments

____

____

____

____

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

HEA 4243 8/06

DENTIST COMPLETES-Exam must be completed within 6 months of start date of school

Ohio Department of Health • School and Adolescent Health

Health History

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

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		

HEA 4240 8/06

(OVER)

PARENT/GUARDIAN COMPLETES

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 / /

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

Ohio Department of Health

REVOCATION SECTION

I do hereby request that this authorization to disclose immunization information of ______________________
(Name of Child/Patient)

signed by ____ on ______________________ be rescinded,
(Enter Name of Person Who Signed Authorization) *(Enter Date of Signature)*

effective ____________________.
(Date)

I understand that any action taken by the named Provider(s) or School in accordance to this authorization prior to the revocation date is legal and binding.

________________________________ ____________ ______________________________ ____________
(Signature of Client/ Patient) *(Date)* *(Signature of Witness)* *(Date)*

________________________________ ____________ ______________________________________
(Signature of Personal Representative) *(Date)* *(Relationship/ Authority)*