# CHILD'S IMMUNIZATION RECORD SIGNED BY DOCTOR

This is to certify that (child's name) ________________________________
DOB ________________was examined by me on (date)_______________.

1) Has had the immunizations required by Section 3313.671 of the Revised Code for admission to school, or has had the immunizations required by the State Department of Health for pre-school and school age children, or is to be exempted from these requirements for medical reasons.

IMMUNIZATION RECORD: (Please enter month, day and year)

| | | | | | |
|---|---|---|---|---|---|
| DPT | 1_______ | 2_______ | 3_______ | 4_______ | 5_______ |
| POLIO | 1_______ | 2_______ | 3_______ | 4_______ | |
| HIB | 1_______ | 2_______ | 3_______ | 4_______ | |
| HEPB | 1_______ | 2_______ | 3_______ | | |

MEASLES, MUMPS, RUBELLA – usually combined as MMR_______
If separate: MEASLES______MUMPS_______RUBELLA_____
*The 5th DPT and the 4th Polio are normally administered just prior to Kindergarten.

2) Based upon his/her medical history and physical condition at the time of this examination, is free from all apparent communicable disease and is in good health for enrollment in school (ages 3 yrs thru 9 yrs).

Physician's Signature_______________________________________

Street Address_____________________________________________

City, State, Zip____________________________________________

Telephone # _______________________________________________

Return via: Fax (513) 271-1684, email: springseastschool@cinci.rr.com, or mail to Springs East School 9429 Loveland-Madeira Rd, Cincinnati, OH 45242

Office of Early Learning and School Readiness

# Child Medical Statement

Revised 3/12/2018

**This form meets Ohio Administrative Code. Programs may use this form or build their own.**

## Section I - Child Medical Information

Child's Name ______________________

Date of Birth ____________ Height ________ Weight ________

| **Immunizations:** | | **Exempt from Immunization:** | |
|---|---|---|---|
| Complete for Age | ◯ Yes ◯ No | Religious Conviction | ◯ Yes ◯ No |
| In Process | ◯ Yes ◯ No | Health | ◯ Yes ◯ No |
| | | Other | ____________ |

Limitations or health conditions, including allergies, medications, and dietary restrictions.

## Section II - Child Medical Statement Verification

Physician/Clinic/Hospital Name ______________ Provider Address ______________

Provider Phone Number ________ Provider City ________ Provider State ________ Provider Zip ________

**Check box of examining medical professional:**

- ☐ Physician
- ☐ Physician Assistant
- ☐ Advanced Practice Registered Nurse

***This child has been examined and is in suitable condition to participate in group care.***

Signature of Medical Professional ______________________ Date of Exam ____________

Programs funded through the Ohio Department of Education must have written policies and procedures to ensure that children have received comprehensive health screenings and/or that families are informed of the importance of health screenings and the resources to obtain them.

## EMERGENCY/CONTACT INFORMATION:

Date Form Completed ________________
Date of Admission____________________

Child's Name ______________________________ Birth date _____________ Current Age (Y.M) ________

Street Address ______________________________________________ County ______________________

City _____________________ State _____ Zip _________ Local School District ______________________

Child's Race/Ethnicity ______________ Cultural Background __________________ Religion _____________

Father's Name_____________________________ Mother's Name________________________________

Cell Phone #_______________________________ Cell Phone #__________________________________

Father's Email ______________________________ Mother's Email _______________________________

Father's Work ______________________________ Mother's Work _______________________________

Father's Business Address____________________ Mother's Business Address______________________

________________________________________ ____________________________________________

Business Phone #__________________________ Business Phone #______________________________

If one of the child's parents does not live at the child's home address, please give address and telephone #:

____________________________________________________________________________________

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The State of Ohio requires three (3) emergency contacts in the event that a parent cannot be reached.

1) Name___________________________________ Relationship to Child________________________
Home Phone #________________ Work # __________________ Cell # _____________________

2) Name___________________________________ Relationship to Child________________________
Home Phone #________________ Work # __________________ Cell # _____________________

3) Name___________________________________ Relationship to Child________________________
Home Phone #________________ Work # __________________ Cell # _____________________

Please list the name(s) of individuals your child may be released to:

____________________________________________________________________________________

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Doctor_____________________________________ Telephone #_______________________________

Address__________________________________ City____________________ State____ Zip______

Dentist_____________________________________ Telephone #_______________________________

Address__________________________________ City____________________ State____ Zip______

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**Health Record Summary**

List of Allergies: ______________________________________________________________________

List of Chronic Physical Problems:_______________________________________________________

List any diseases child has had:_________________________________________________________

History of Hospitalization: ______________________________________________________________

List any medications, food supplements, and modified diet or fluoride supplements currently being administered to child: _________________________________________________________________
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# CONSENT AUTHORIZATION

Date Form Completed _______________

## Part I: PERMISSION GRANTING CONSENT

I give Springs East School permission to transport my child, ______________________________
1) To (Hospital or Clinic) __________________________________________ for emergency medical care.
2) To (Dentist or Clinic) ___________________________________________ for emergency dental care or to the nearest available source of assistance.
3) To and from Springs East School for reasons such as field trips and other special events.
4) To or from the Public School, in the event my child misses their Kindergarten bus.

## Part II: REFUSAL TO GRANT CONSENT

I do not give permission to Springs East School to transport my child, ______________________ for emergency medical or dental care. In the event of an illness or injury which requires emergency medical or dental treatment, I wish the following action to be taken:

_________________________________________________________________________________

_________________________________________________________________________________

(detail your wishes here)

SIGNATURE OF PARENT ___________________________________________________

## SOCIAL MEDIA PERMISSION

_______ I grant permission to have my child's picture included in the school social media on our school Facebook page and our school website.

_______ I do not want my child's picture included in the school Facebook page or on the school website.

SIGNATURE OF PARENT ___________________________________________________

## DIRECTORY PERMISSION

Note: This directory is published **only** to parents and staff.

_______ I grant permission to have my child's name, address, and phone number included in the school directory.

_______ I do not want my child's name, address, and phone number included in the school directory.

SIGNATURE OF PARENT ___________________________________________________

## VERIFY THAT YOU HAVE READ OUR DISCIPLINE POLICY

_______ I have read the Discipline Policy in the Springs East Montessori School Handbook.

SIGNATURE OF PARENT ___________________________________________________