

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



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 _____

Table with 2 columns: Immunizations and Exempt from Immunization. Rows include Complete for Age, In Process, Religious Conviction, Health, and Other.

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

Large empty box for entering limitations or health conditions.

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 _____

Child's Name _____ Birth date _____ Date of Admission _____

Full Address _____ City _____ State _____ Zip _____

Home Phone _____ Child's 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 #:

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:

Doctor _____ Telephone # _____

Address _____ City _____ State _____ Zip _____

Dentist _____ Telephone # _____

Address _____ City _____ State _____ Zip _____

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: _____

Immunization Record: Enter month/day/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 _____

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 _____