BEDFORD CITY SCHOOL DISTRICT

PROUDLY SERVING BEDFORD • BEDFORD HTS. • WALTON HILLS • OAKWOOD

Note from the Health Services Team

Dear Parents/Guardians of Students entering Kindergarten,

It is with great anticipation that we await your child's entrance into Kindergarten this fall. Bedford City School District wants to ensure the health and safety of our students.

The following forms are necessary for school entry and will be reviewed by the school nurse prior to entry:

1. **IMMUNIZATION RECORD** - an up-to-date, complete immunization record is REQUIRED AT REGISTRATION. Please bring your child's MOST UP-TO-DATE record. We can make a copy if you have the original. The state of Ohio requires the following immunizations for school entry:

    - DPT, DTap — 4 doses (5 doses required if final dose given before 4th birthday)
    - Polio — 3 doses (4 doses required if final dose on/after 4th birthday or if OPV/IPV combination)
    - MMR — 2 does
    - Hepatitis B — 3 doses
    - Varicella — 2 doses or documented date of disease

    According to Section 3313.671, *on the 15th day after school entrance*, students who do not meet immunization requirements may be *excluded from school*.

2. **PHYSICAL EXAMINATION FORM (enclosed)** Must be completed and signed by your child's Healthcare Provider. The exam must occur within twelve months prior to the date of admission.

If your child has a medical condition that may require interventions at school (i.e. asthma, allergies, medication administration, diabetes, tube feedings, ect.), you will be required to complete additional forms that will need to be *signed by your child's Healthcare Provider*. Please find health forms on the school website and contact the nurse so that appropriate accommodations may be made for school.

We look forward to having your child in the Bedford City School District next year!

Thank you!

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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

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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						

Signature of HealthCare Provider:	Print Name of HCP:	Date
		/ /