BEDFORD CITY SCHOOL DISTRICT

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

Bright Beginnings Preschool Program

****REQUIRED HEALTH FORMS****

Dear Parents/Guardians of Children Entering Preschool:

It is with great excitement that we await your child's entrance into Preschool. Bedford City School District's health services goal is to ensure that our students are healthy, safe and able to attend school. The Ohio Department of Education requires the following documents for school entry.

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

1. Current **Immunization Record**. **REQUIRED AT REGISTRATION**. Please bring the record even if your child has not had the final boosters yet. We can make a copy if you have the original. The State of Ohio health law requires the following immunizations for school entry:

Immunization	**Required dose(s)**	** As determined by your child's Healthcare Provider*
DPT, DTaP	4 doses	*5th dose*
Polio	3 doses	*4th dose*
MMR	1 doses	*2nd dose by Kindergarten*
Varicella	1 doses or documented date of disease	*2nd dose by Kindergarten*
HIB	4 doses	
Hepatitis B	3 doses	
Pneumococcal Disease	4 doses	
Hepatitis A	2 doses	
Influenza	*1 dose*	

If your child is exempt from receiving immunizations due to a medical contraindication or reason of good conscience, including religious convictions, you must complete the *Immunization Exemption Form* which may be found on the school website or you may request it from the school nurse. This form must be completed annually.

2. **Physical Examination** (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 intervention at school (i.e. asthma, allergies, diabetes, medications to be administered during school hours,ect.) you will be required to complete additional forms that will need to be signed by your child's Healthcare Provider. Please find forms on the school website or contact the school nurse for further guidance.

Forms may be mailed directly to Glendale Primary School at 400 W Glendale St, Bedford, OH 44146, attention to Kenadi Kissell, Nurse or faxed to 440-439-3487.

We look forward to having your child at Glendale Primary School.

Thank you,
Kenadi Kissell, RN
Nurse
440-439-4227 ext. 6736

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Bedford City School District
Preschool Entrance Physical Examination
(To be completed by your child's Healthcare Provider)

According to OAC 3301-37-08 The examination shall occur within twelve months prior to the date of admission.

THIS IS TO CERTIFY THAT I HAVE EXAMINED:	Date of Examination:
CHILD'S NAME:	
CHILD'S DOB:	

Required Immunizations for School Entry

1. Please complete the following by entering the Month/Day/Year that each immunization was administered. Or you may attach an up to date immunization record to this form.
2. If the child is exempt due to medical contraindications, list reasons for the medical exemption and sign below:

   _____

   Healthcare Provider Signature:_____

DTP	1.	2.	3.	4.	5.*	*As determined by HCP
POLIO (IPV)	1.	2.	3.	4.*		*As determined by HCP
MMR*	1.	2.	Measles	Mumps	Rubella	2nd Dose Required Prior to Kindergarten
HEPATITIS B	1.	2.	3.			
VARICELLA (CHICKENPOX)	1.	2.*	Date of Disease:			*2nd Dose required for Kindergarten
HIB	1.	2.	3.	4.		
HEPATITIS A	1.	2.				1st Dose after 12 months old
INFLUENZA	1.					
(PNEUMOCOCCAL)	1.	2.	3.	4.		
ROTOVIRUS						

*If Measles, Mumps, Rubella not given as MMR, give dates for each immunization

REQUIRED SCREENINGS: PLEASE INDICATE THE RESULTS OF ANY SCREENINGS

SCREENING	DATE	RESULTS	RESULTS NOT COMPLETED	FOLLOW-UP REQUIRED? WHEN
Vision		R 20/____ L 20/____ ou 20/___		
Hearing		R ear Pass/Fail L ear Pass/Fail		
Speech				
Height				
Weight				
Lead Screening			Not at risk__Not indicated__	
Hematocrit or Hemoglobin			Not at risk__Not indicated__	

CHILD'S NAME: _____DATE OF BIRTH:_____

Chronic Health Concerns: ____Asthma ____Seizure Disorder ____ADD/ADHD ___Diabetes
Other:_____

Date of Examination _____	Yes	No	Findings
General Appearance			
Skin			
Lymph Nodes			
Eyes			
Ears			
Nose/Throat			
Dental: Teeth/Gums/Tongue/Palate			
Heart			Blood Pressure:
Lungs			
Abdomen			
Genitals			
Skeletal system			
Neuromuscular			
Allergies:			Type: Treatment:

List any food supplements or modified diets currently required:

Current medications AND dosage child is receiving (if any medications will be administered at school, please complete an *Authorization to Administer Medication Form* (form may be found on school website):
Medication Name: Dosage: Time of Administration:

THE ABOVE NAMED STUDENT IS FREE FROM APPARENT COMMUNICABLE DISEASE AND IS IN SUITABLE CONDITION TO ATTEND A PRESCHOOL PROGRAM, BASED ON HIS/HER MEDICAL HISTORY AND PHYSICAL CONDITION AT THE TIME OF THIS EXAMINATION (THIS INFORMATION IS REQUIRED PRIOR TO THE FIRST DAY OF ATTENDANCE).

Physician's Signature	Date Completed:
Physician's Name (Print)	
Physician's Address City, State, Zip Code	
Physician Phone	
Parent(s)/Guardian Name	
Parent/Guardian Signature	

A MEDICAL STATEMENT IS REQUIRED EVERY 13 MONTHS FROM THE DATE OF THE EXAMINATION THEREAFTER.