

THE SUMMIT COUNTRY DAY SCHOOL
2161 Grandin Road
Cincinnati, OH 45208-3300

PHYSICAL EXAMINATION AND IMMUNIZATION RECORD FORM

Student's Name _____ Birth Date ____/____/____

Address _____ Phone _____

Grade Entering _____

OHIO LAW, Section 3312.671 and 3313.7II, Revised Code, **REQUIRES** that we admit only those students to school who have completed the required physical and immunizations as listed on this form.

The State of Ohio requires that all **Pre-Primary Montessori students** to have an annual PHYSICAL EXAMINATION AND IMMUNIZATION RECORD FORM on file in the Pre-Primary clinic each year. The State also requires **all new** students to have a Physical and Immunization Form on file in the school clinic. The Summit Country Day Health Policy requires **all students entering grades 1, 5 and 9 to have a new Physical and an updated Immunization Form.**

Please return this completed form to The Summit Country Day School Admission Office.

TO BE COMPLETED BY PHYSICIAN

PHYSICAL EXAMINATION

Student _____ **EXAMINATION_DATE** _____

Age _____ Height _____ Weight _____

Physical examination normal, except: _____

Hearing Test _____ Vision Test _____

Hearing and vision testing is required by the State of Ohio for **all new** students entering school.

Student is considered able to participate in all regular athletic and other activities, except: _____

Medications: _____

Allergies: _____

Signature of Physician _____ Date _____

Please print name of physician _____

TO BE COMPLETED BY PARENT, GUARDIAN, OR PHYSICIAN

B. IMMUNIZATION RECORD

DTaP/DTP/DT Series and Boosters

Pre-Primary Montessori students are required to have 4 doses of DTaP, DTP, or DT (Pediatric) or any combination. Students, who received 4 doses before their 4th birthday, must receive a 5th dose. Students in grades 1st –12th who received 4 doses before their 4th birthday must receive a 5th dose.

1st _____ 2nd _____ 3rd _____ 4th _____ 5th _____
 Month/Day/Year Month/Day/Year Month/Day/Year Month/Day/Year Month/Day/Year

DT Booster _____
 Month/Day/Year Month/Day/Year

Polio Series OPV/IP

Students who receive 3 doses before 4th birthday must receive a 4th dose of Polio Vaccine.

1st _____ 2nd _____ 3rd _____ 4th _____ 5th _____
 Month/Day/Year Month/Day/Year Month/Day/Year Month/Day/Year Month/Day/Year

MMR (Measles, Mumps, Rubella)

Requirements for Pre-primary Montessori: one dose of MMR must be received on or after first birthday.
Requirements for a child who turns 5 year olds by September 30th of the school year & 1st - 12th grades: a second dose of MMR is required. The second dose must be administered at least 28 days after first dose.

MMR 1st _____ **OR** Measles (rubeola, 10 Day) 1st _____ 2nd _____
 Month/Day/Year Month/Day/Year Month/Day/Year
 2nd _____ Mumps 1st _____ 2nd _____
 Month/Day/Year Month/Day/Year Month/Day/Year
 Rubella (3 Day) 1st _____ 2nd _____
 Month/Day/Year Month/Day/Year

HIB (Haemophilus influenzae Type B) Required for all Pre-Primary Montessori children
The number of doses will vary depending on the type of vaccine.

1st _____ 2nd _____ 3rd _____ 4th _____
 Month/Day/Year Month/Day/Year Month/Day/Year Month/Day/Year

Hepatitis B Series Second dose must be at least 28 days from 1st dose, third dose must be at least 2 months from the 2nd and 4 months from the 1st dose . The last dose can not be given before 24 weeks of age.

Required for all Pre-Primary Montessori through 9th grade students

Meningococcal Vaccine

1st _____ 2nd _____ 3rd _____ 4th _____
 Month/Day/Year Month/Day/Year Month/Day/Year Month/Day/Year

Varicella (Chickenpox)

Pneumococcal Conjugate (PCV7)

Hepatitis A

Required for Kdg -2n Grade

Date _____ Date _____

Date _____ Date _____ Date _____ Date _____

Date _____ Date _____

Date _____

Tuberculin Test

Required only if student is entering school from outside the Continental United States.

HPV-16 (Human Papilloma Virus)

Date _____ Type _____ Negative _____ Positive _____

Date _____ Date _____ Date _____

Signature of Parent or Guardian _____ Date _____

Please print Parent or Guardian Name _____

RETURN COMPLETED FORM TO:
 ADMISSION OFFICE
 THE SUMMIT COUNTRY DAY SCHOOL
 2161 GRANDIN ROAD
 CINCINNATI, OH 45208-3300

Ohio Department of Health • School and Adolescent Health

Health History

Student's name	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth / /
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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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Was infant born full term? <input type="checkbox"/> Yes <input type="checkbox"/> No	Did the infant have any sickness or problems? <input type="checkbox"/> Yes <input type="checkbox"/> No
Briefly explain illness or problems. <hr/>	
How does the child's development compare to other children, such as his or her brothers/sisters or playmates? <input type="checkbox"/> About the same <input type="checkbox"/> Delayed <input type="checkbox"/> Advanced	

Student Health Conditions

<input type="checkbox"/> YES , my child receives regular medical/health care for the following conditions:		<input type="checkbox"/> NO medical conditions
<input type="checkbox"/> Allergies	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Seizure disorder
<input type="checkbox"/> Asthma	<input type="checkbox"/> Depression	<input type="checkbox"/> Sickle cell anemia
<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Ear problem/hearing difficulty	<input type="checkbox"/> Skin conditions
<input type="checkbox"/> Autism	<input type="checkbox"/> Emotional concerns	<input type="checkbox"/> Speech problems
<input type="checkbox"/> Behavior concerns	<input type="checkbox"/> Headaches	<input type="checkbox"/> Traumatic brain injury
<input type="checkbox"/> Birth/congenital malformations	<input type="checkbox"/> Heart problems	<input type="checkbox"/> Vision problems (glasses, contacts)
<input type="checkbox"/> Bone/muscle/joint problems	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Other _____
<input type="checkbox"/> Blood problems	<input type="checkbox"/> Juvenile arthritis	<input type="checkbox"/> Other _____
<input type="checkbox"/> Bowel/bladder problems	<input type="checkbox"/> Lead poisoning	<input type="checkbox"/> Other _____
<input type="checkbox"/> Cancer	<input type="checkbox"/> Migraines	<input type="checkbox"/> Other _____
<input type="checkbox"/> Cystic fibrosis	<input type="checkbox"/> Neuromuscular disorder	<input type="checkbox"/> 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
<input type="checkbox"/> Bee/Insect		
<input type="checkbox"/> Food		
<input type="checkbox"/> Medication		
<input type="checkbox"/> Other		

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 / /
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