Revised 1/23/2008

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 3313.7ll, 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 ______________________________

-OVER-

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 ______________
Month/Day/Year

2nd ______________
Month/Day/Year

OR

Measles (rubeola, 10 Day) 1st____________ 2nd____________
Month/Day/Year Month/Day/Year

Mumps 1st____________ 2nd____________
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

1st__________ 2nd__________ 3rd__________ 4th__________
Month/Day/Year Month/Day/Year Month/Day/Year Month/Day/Year

Meningococcal Vaccine

____
Month/Day/Year

Varicella (Chickenpox)
Required for Kdg -2n Grade
Date_____ Date_______

Pneumococcal Conjugate (PCV7)
Date_______ Date______Date_______ Date__________
Date_______

Hepatitis A
Date________ Date__________

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

Date ____________Type___________ Negative _______ Positive _____

HPV-16 (Human Papilloma Virus)

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	Date of birth
	☐ Male ☐ Female	/ /

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? ☐ Yes ☐ No

Was infant born full term? ☐ Yes ☐ No Did the infant have any sickness or problems? ☐ Yes ☐ No

Briefly explain illness or problems.

___

How does the child's development compare to other children, such as his or her brothers/sisters or playmates?

☐ About the same ☐ Delayed ☐ Advanced

Student Health Conditions

☐ **YES,** my child receives regular medical/health care for the following conditions: ☐ **NO** medical conditions

☐ Allergies	☐ Diabetes	☐ Seizure disorder
☐ Asthma	☐ Depression	☐ Sickle cell anemia
☐ ADD/ADHD	☐ Ear problem/hearing difficulty	☐ Skin conditions
☐ Autism	☐ Emotional concerns	☐ Speech problems
☐ Behavior concerns	☐ Headaches	☐ Traumatic brain injury
☐ Birth/congenital malformations	☐ Heart problems	☐ Vision problems (glasses, contacts)
☐ Bone/muscle/joint problems	☐ Hemophilia	☐ Other___
☐ Blood problems	☐ Juvenile arthritis	☐ Other___
☐ Bowel/bladder problems	☐ Lead poisoning	☐ Other___
☐ Cancer	☐ Migraines	☐ Other___
☐ Cystic fibrosis	☐ Neuromuscular disorder	☐ 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
☐ Bee/Insect		
☐ Food		
☐ Medication		
☐ 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
		/ /