

## HEALTH EXAMINATION RECORD AND IMMUNIZATIONS

The Ohio Department of Health has established the following minimal requirements for pupils in public and non-public schools (Ohio Law Sections 3313.671 and 3701.13 of the Ohio Revised Code):

- Five (5) doses of DTap, DTP or DT or any combination (Diphtheria, Tetanus, Pertussis) if the 4<sup>th</sup> dose was administered before the 4<sup>th</sup> birthday
- Four doses of any combination of OPV or IPV is required; the final dose of polio vaccine must have been administered on or after the 4<sup>th</sup> birthday, regardless of the number of previous doses.
- Three doses of Hepatitis B vaccine; the second dose must be given at least 28 days after the first dose, and the third dose at least 8 weeks after the second dose and at least 16 weeks after the first dose.
- Two (2) doses of MMR [Measles (Rubeola), Mumps, and Rubella (German Measles)] vaccine are required. The first dose must have been received on or after the 1<sup>st</sup> birthday and the second dose at least 28 days after the first dose.
- One TB test and the result of that test within one year of the first day of school is highly recommended (but not required) for admittance to VCA.
- Two (2) doses of varicella vaccine; the first (1<sup>st</sup>) dose of vaccine must be given on or after the child's first (1<sup>st</sup>) birthday, and the second (2<sup>nd</sup>) dose at least 28 days following the first dose.

According to Section 3313.671, on the 15<sup>th</sup> day after school entrance it will be necessary to exclude all students from school who do not meet the above requirements.

If there is a medical reason your child has not received all the immunizations required for school admittance, your physician must certify in writing that such immunization against that disease is medically contraindicated. A medical, religious or philosophical exemption form is to be signed by the doctor.

If you have chosen not to have your child immunized as required by the Ohio Revised Code, a medical, religious or philosophical form is to be completed and turned in to the school along with the medical history form. Records must include the month, day and year the vaccination was received.

Attached you will find the student health information form.

The *Medical History* side of the form is for you to fill out. The side for *Immunizations* and *Physical Examination* is for your physician to fill out. If your child has already seen his doctor for the kindergarten exam, please take the form to the medical office to be completed and sent to school.



## IMMUNIZATIONS

Please write dates in the following blanks (M/D/Y):

Tuberculin Test: Type \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_ Result \_\_\_\_\_

DPT            1<sup>st</sup> \_\_\_\_ / \_\_\_\_ / \_\_\_\_    2<sup>nd</sup> \_\_\_\_ / \_\_\_\_ / \_\_\_\_    3<sup>rd</sup> \_\_\_\_ / \_\_\_\_ / \_\_\_\_    4<sup>th</sup> \_\_\_\_ / \_\_\_\_ / \_\_\_\_    5<sup>th</sup> \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Polio Vaccine: Type \_\_\_\_\_

                  1<sup>st</sup> \_\_\_\_ / \_\_\_\_ / \_\_\_\_    2<sup>nd</sup> \_\_\_\_ / \_\_\_\_ / \_\_\_\_    3<sup>rd</sup> \_\_\_\_ / \_\_\_\_ / \_\_\_\_    4<sup>th</sup> \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Measles (regular)    \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (must be on or after first birthday)

Rubella (German)    \_\_\_\_ / \_\_\_\_ / \_\_\_\_    Mumps \_\_\_\_ / \_\_\_\_ / \_\_\_\_    MMR1 Combined \_\_\_\_ / \_\_\_\_ / \_\_\_\_    MMR2 Combined

                  \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Hepatitis B    1<sup>st</sup> \_\_\_\_ / \_\_\_\_ / \_\_\_\_    2<sup>nd</sup> \_\_\_\_ / \_\_\_\_ / \_\_\_\_    3<sup>rd</sup> \_\_\_\_ / \_\_\_\_ / \_\_\_\_    Varicella \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Other (give type and date): \_\_\_\_\_

## PHYSICAL EXAMINATION

*Please have your physician complete this portion.*

Height \_\_\_\_\_

Vision:            Right:    Left:           

Hearing:

Weight \_\_\_\_\_

                  with glasses    \_\_\_\_\_    \_\_\_\_\_

Normal

Blood Pressure \_\_\_\_\_

                  without glasses    \_\_\_\_\_    \_\_\_\_\_

Abnormal

Normal	Abnormal		Comments:
		Head, face, and scalp	
		Teeth	
		Nose and sinus	
		Eyes	
		Ears	Allergies:
		Mouth and throat	
		Neck (thyroid)	
		Chest and lungs	
		Heart	Medications:
		Abdomen	
		Genitalia	
		Back and Extremities	
		Skin	Restrictions regarding physical activities or sports:
		Rectum and anus	
		Neurological	

Physician's Signature: \_\_\_\_\_ Phone: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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