GESU CATHOLIC SCHOOL

2045 Parkside Blvd. ◆ Toledo, OH 43607 ◆ (419) 536-5634 ◆ Fax (419) 531-8932

Dear Parents of Kindergarten Students:

The Ohio Department of Health requires all students to have the following information on file in the school office by the first day of school.

- A physical exam signed by a doctor that is less than one year old.
- A dental exam by a dentist.
- All current immunizations from the doctor's office.
- A parent to complete a health history for each child.
- An Emergency Medical Authorization form for each child signed by the parent.

Any child without the above information can be excluded from school.

The above information is needed by the first week of September at the latest.

If you need forms for the above, please ask at the main office or the nurse's office for a copy.

If your child is on medications or has special medical concerns, please call, email, or stop in.

Thank you for your attention to these important matters.

Aaron McMunn, RN
School Nurse

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PHYSICIAN'S REPORT

Child's Name: _____

Age: _____ (years) _____ (months)

Immunizations: Kindergarten: 5 DPT, 4 Polio, 2 MMR, 3 Hepatitis B, 2 Varicella
Preschool: 4 DPT, 3 Polio, 1 MMR and 3 HIB, 3 Hepatitis B, 1 Varicella

DPT	1._____	2._____	3._____	4._____	5._____
Polio	1._____	2._____	3._____	4._____	5._____
MMR	1._____	2._____			
Hep B	1._____	2._____	3._____		
HIB	1._____	2._____	3._____	4._____	
Varicella	1._____	2._____			

Screening Tests:

VISION

Distance Acuity R_____ L_____

Near Acuity _____ Pass _____ Fail

Muscle Balance _____ Pass _____ Fail

Wears glasses? ☐ Yes ☐ No

Referral made? ☐ Yes ☐ No

HEARING (pass/fail)

Pure Tone R ____ L____

Impedance R ____ L____

Frequent Ear Infections? _____

Does child have tubes?

Right _____ (Date placed)

Left _____ (Date placed)

Physical Exam

Essentially normal: _____ Abnormalities as follows: _____

Current Medication: _____

Allergies: (medications, insect stings, food, animals, etc.) _____

Is this child able to participate in all school activities? ☐ Yes ☐ No

If no, please explain: _____

This is to certify that the above named student has been seen in our office and is able to participate in a preschool or kindergarten program.

Physician's Signature: _____ Date of Exam: _____

Physician's Name: _____

Address: _____ (print or stamp)

_____

Phone: (___) _____

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DENTIST'S REPORT

Name: _____ Grade: _____

The following services were performed (Please check)

_____Exam _____ Fluoride treatment _____ Dental sealants

_____Diagnosis _____ Radiographs _____ Oral Prophylaxis

_____Other _____

Dentist Signature: _____ Date of Exam: _____

Dentist's Name: _____

Address: _____ (print or stamp)

_____

Phone: (___) _____

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HEALTH HISTORY

PRESCHOOL / KINDERGARTEN (circle one)

Child's Name: _____ D.O.B. _____

Male □ Female □

Mother's Name: _____ Father's Name: _____

With whom does the child live: _____ Legal Guardian? Yes □ No □
Telephone Number: (___) _____

PERINATAL/DEVELOPMENTAL HISTORY

Infant born: Full Term □ Premature □ Birth Weight: _____

Any illness or problems while in the nursery? _____

Approximate age at which this child:
Walked alone _____ Toilet Trained _____
Spoke in Sentences _____ Dressed Self _____

How does this child's development compare to siblings or playmates?
About the same □ Slower □ Faster □

MEDICAL HISTORY

Health Conditions (i.e. asthma, diabetes) _____
_____
History of Hospitalization _____
_____
Allergies (food/plant/animal/drug) _____
_____
Childhood Diseases (i.e. chicken pox) _____
_____
Medication (taken on a regular basis) _____
_____
Do you have other comments about your child's health, development, behavior, family or home life that you feel the school should be aware of? If so, please explain. _____
_____
_____

Completed by: _____ Date: _____
Relationship: _____