PRESCHOOL IMMUNIZATION REQUIREMENTS

Ohio State Law requires that the following immunizations be obtained for school enrollment. Students who do not have the required immunizations will be excluded from school per Ohio State Law until such record is provided. **You must bring an immunization record with the month/date/year for each of the shots below to preschool registration in order to complete enrollment requirements.**

4 - DTaP

3- Polio

1 - MMR

3 - Hepatitis B

1 - Varicella (chicken pox) – (or documentation of having disease)

Please contact your family physician or the Pickaway County Health Department at (740) 477-9667 to arrange for your child to receive an update on his/her immunizations. The health department might be able to provide vaccinations to your child for a minimal amount or on a sliding fee scale. You must call the Health Department at (740) 477-9667 to make an appointment. A parent (or legal guardian) and a copy of the child's current immunization record must accompany the child to the Health Department. If you have any questions concerning your child's immunizations, please contact the District School Nurse's office at (740) 474-2345, ext. 47048 or the Health Department at (740) 477-9667.

In closing, if your child has any serious medical concerns (i.e. seizures, diabetes, hemophilia, heart condition, etc.) or will require medication during school hours, please contact the District School Nurse's office at (740) 474-2495, ext. 49099 before the start of school and list this information on the Emergency Medical Form. There are certain permission forms that will need to be completed and it may be necessary to create a care plan to ensure your child's health at school. Please remember that student health information will be shared with school personnel unless you request otherwise. **In addition, all preschoolers will receive a vision and hearing screening in the fall as part of our school health program.** We look forward to meeting your child in the fall!

Thank you,

Jaime McKeivier, BSN, RN, LSN

District School Nurse

Circleville City Schools

740-474-2495, ext. 49099

jaime.mckeivier@cvcsd.com

AUTHORIZATION TO DISCLOSE IMMUNIZATION INFORMATION

Name of Child _____ Date of Birth _____

I, _____ as the **parent or guardian** of the above named child, hereby authorize (**name of doctor(s**) _____

_____

_____

to disclose the specific and individually identifiable immunization records of the above named child to ***Circleville City Schools*** for the specific purpose of presenting written evidence, satisfactory to the person in charge of admission, that the above named child has been immunized by a method of immunization approved by the Department of Health as required by section 3313.671 of the Ohio Revised Code.

This authorization will expire upon the presentation of written evidence sufficient to comply with section 3313.671 of the Ohio Revised Code or for the period of time needed to fulfill its purpose. I also understand that I may revoke this authorization, in writing, at any time and that I may be asked to sign the *Revocation Section*. I further understand that any action taken by the above named Provider(s) or School in accordance to this authorization prior to it being revoked is legal and binding.

I understand that my information may not be protected from re-disclosure by the requester of the information unless otherwise provided for by state or federal law. **Please note: medical records provided to schools that receive federal funding are protected by the Family Education Rights and Privacy Act (FERPA).**

I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given.

I also understand that my refusal to sign this authorization may prevent the school from verifying that the above named child has been immunized. I further understand that if the school cannot verify and I cannot provide satisfactory written evidence that above named child has been immunized the child may be excluded from school pursuant to section 3313.671 of the Ohio Revised Code.

I further understand that I may request a copy of this signed authorization.

_____ _____ _____

(Signature of Personal Representative) *(Date)* *(Relationship/Authority)*

****

Note: *This Authorization was revoked on:* _____ _____

(Date) *(Signature of Staff)*

AUTHORIZATION TO DISCLOSE IMMUNIZATION INFORMATION

Fill out this section if you do not want the school to contact your health care provider.

REVOCATION SECTION

I do hereby request that this authorization to disclose health information of _____
(Name of Child/Patient)

signed by _____ on _____
(Name of person who signed authorization) *(Date of Signature)*

be rescinded, effective _____.
(Date)

I understand that any action taken by the named Provider(s) or School in accordance to this authorization prior to the revocation date is legal and binding.

_____ _____ _____ _____
(Signature of Client/Patient) *(Date)* *(Signature of Witness)* *(Date)*

_____ _____ _____
(Signature of Personal Representative) *(Date)* *(Relationship/Authority)*

N52-04

Ohio | Department of Education

Office of Early Learning and School Readiness

Child Medical Statement

Revised 7/11/2016

This form meets Ohio Administrative Code. Programs may use this form or build their own.

Section I - Child Medical Information

Child's Name _____

Date of Birth _____ Height _____ Weight _____

Immunizations:		**Exempt from Immunization:**	
Complete for Age	◯ Yes ◯ No	Religious Conviction	◯ Yes ◯ No
In Process	◯ Yes ◯ No	Health	◯ Yes ◯ No
		Other	

Limitations or health conditions, including allergies, medications, and dietary restrictions.

Section II - Child Medical Statement Verification

Physician/Clinic/Hospital Name _____ Provider Address _____

Provider Phone Number _____ Provider City _____ Provider State _____ Provider Zip _____

Check box of examining medical professional:

- ☐ Physician
- ☐ Physician's Assistant
- ☐ Advanced Practice Nurse

This child has been examined and is in suitable condition to participate in group care.

Signature of Medical Professional _____ Date of Exam _____

Programs funded through the Ohio Department of Education must have written policies and procedures to ensure that children have received comprehensive health screenings and/or that families are informed of the importance of health screenings and the resources to obtain them.

Confidential Dental Health Record

Child's Name _____ Sex: M F Birthdate: _____
Dentist: _____Address: _____Phone _____

PART A: To be completed by Parent/Guardian:

1. Is the child now receiving fluoride? If "yes", include length of time

Topical Fluoride Application? No _____ Unknown _____ Yes _____

Fluoridated water? No _____ Unknown _____ Yes _____

Fluoride supplement diet? No _____ Unknown _____ Yes _____
(tablets, liquid)

2. Does the child have any trouble with teeth, gums, or mouth that the parent knows about?
   No _____ Yes _____

3. Child (____has _____has not) previously seen a dentist
   Dentist name: _____ Date of last visit: _____

4. Child (_____is_____is not) under a physician's care
   Physician's name: _____ Date of last visit: _____

5. Child (_____is_____is not) receiving medication
   Type
   _____

6. Child is reported to have:
   Allergies _____ Liver Disease _____
   Asthma _____ Rheumatic Fever _____
   Bleeding _____ Sickle cell disorder _____
   Diabetes _____ Heart/Vas. Disorder _____
   Epilepsy _____ Other _____

PART B: Parental Consent:
I have been informed of my child's dental health plan and agree to the recommended treatment.
Parent signature: _____ Date: _____

PART C: To be completed by dental care provider:

1. Oral conditions before treatment:

Missing: ⊗

Decayed: ●

Filled: ⊙

Indicate restorations you perform in item 2.

2. Examination and Treatment Record:

Tooth ID	Surfaces	Description of work	Treatment Approved	Date Performed	A.D.A.#	Fee

3. Dental needs:
Treatment _____ Fluoride _____ Approx # of visits ____
(restoration, extraction,
Pulp therapy) _____ Cleaning _____ Approx cost _____

No problems ____ Other _____

4. Child Oral Health Summary
All planned treatment (____is____is not) complete. If not, explain here:
_____

Routine recall visits _____ Developmental problems _____
Dietary problems _____ Special home emphasis, oral hygiene ____
Needs fluoride supplement _____ Harmful oral habits _____

Dentist signature _____ Date _____