Dear Parents,

Welcome to Anthony Wayne! You will find two Kindergarten Health Forms to download from the online registration process, Physician’s Report for Kindergarten and the Oral Assessment. You may turn completed forms to the office on your child’s designated screening day in June or at Picture Day in August. It is highly recommended you take your child for a professional eye examination. Vision disorders are the fourth most common disability in the United States and the most prevalent handicapping condition during childhood. Minimal vision screenings are conducted at school in the fall.

Please take note, an up-to-date Immunization Record (including 5 year old shots) must be turned in to the office by WEDNESDAY, SEPTEMBER 9, 2020 or your child WILL be excluded from school starting THURSDAY, SEPTEMBER 10, 2020. This is in accordance with Ohio law (Ohio Revised Code 3313.67/3313.671).

Physician’s Report for Kindergarten
- To be completed and signed by your child’s Physician. Please have this form completed from your child’s 5th year physical exam.
- A copy of your immunization record is acceptable.
- Letter of Objection is needed for any immunization objection. You can obtain this form from your building’s nurse.

Oral Assessment
- To be completed and signed by your child’s Dentist

Please call the school office if you have questions, we would be happy to help you.

Fay Birkemeier, RN  Valerie Bradfield, RN  Laura Soeder, RN
Monclova Primary  Waterville Primary  Whitehouse Primary
419-865-9408  419-878-2436  419-877-0543
Anthony Wayne Local Schools

PHYSICIAN’S REPORT FOR KINDERGARTEN

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Student’s Name

Sex (circle)

Date of Birth

<table>
<thead>
<tr>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
</table>

Health History (Serious or chronic illnesses/injuries/surgeries/medications)

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Physical Examination (Date: ________________________)

- [ ] Essentially Normal
- [ ] Abnormalities as follows

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Is this child able to participate fully in:

<table>
<thead>
<tr>
<th>Classroom and academic activities</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical education classes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Competition athletics</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Contact and collision sports</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

If limitations are advised, please specify

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Does this child have any physical, developmental or behavioral issues that may affect his/her educational process?

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IMMUNIZATIONS

Students are required to be immunized in accordance with Ohio law (Ohio Revised Code 3313.67/3313.671).

A copy of the child’s immunization record may be attached or dates may be entered below.

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>DTAP</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Polio</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B</td>
<td></td>
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</tr>
<tr>
<td>MMR</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Varicella</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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Health Care Provider’s Signature

Address

Print Name

Phone Number
Ohio Department of Health • School and Adolescent Health

Oral Assessment

<table>
<thead>
<tr>
<th>Student’s name</th>
<th>Date of birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>/ /</td>
</tr>
</tbody>
</table>

The following services have been performed (please check all that apply)

- [ ] Examination
- [ ] Fluoride application
- [ ] Oral prophylaxis (cleaning)
- [ ] Prescription for fluoride supplement
- [ ] Orthodontic assessment
- [ ] Radiographs
- [ ] Dental sealant
- [ ] Treatment (restoration, pulp therapy)
- [ ] Other

The following oral hygiene instruction was provided (please check all that apply)

- [ ] Toothbrushing
- [ ] Flossing
- [ ] Dietary counseling
- [ ] Use of fluoride mouthrinse
- [ ] Other

The following statements are applicable (please check all that apply)

- [ ] All necessary preventive services have been performed. (Fluoride treatment, prophylaxis)
- [ ] No restorative services are required at this time.
- [ ] Further treatment is indicated. (See comments)
- [ ] Further appointments have been arranged. (Orthodontic, restorative)
- [ ] Routine recall visits recommended.

Comments

__________________________________________________________________________________________________________________________________________

__________________________________________________________________________________________________________________________________________

__________________________________________________________________________________________________________________________________________

__________________________________________________________________________________________________________________________________________

__________________________________________________________________________________________________________________________________________

Dentist’s signature | Print name | Phone

( )

Address | Date

/ / |

City | State | ZIP

HEA 4243  8/06