

Kindergarten



Health Forms

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 return your completed forms during your registration appointment or to your child's building office. 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 **TUESDAY, SEPTEMBER 7, 2021** or your child **WILL be excluded from school starting WEDNESDAY, SEPTEMBER 8, 2021**. 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
Monclova Primary
419-865-9408

Valerie Bradfield, RN
Waterville Primary
419-878-2436

Laura Soeder, RN
Whitehouse Primary
419-877-0543

Anthony Wayne Local Schools
PHYSICIAN'S REPORT FOR KINDERGARTEN

Student's Name	Sex (circle) Male Female	Date of Birth
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Health History (Serious or chronic illnesses/injuries/surgeries/medications)

Physical Examination (Date: _____)

Essentially Normal Abnormalities as follows

Is this child able to participate fully in:

Classroom and academic activities	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Physical education classes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Competition athletics	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Contact and collision sports	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If limitations are advised, please specify

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

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.

	Date	Date	Date	Date	Date
DTAP					
Polio					
Hepatitis B					
MMR					
Varicella					

Health Care Provider's Signature	Address
Print Name	
Date	Phone Number

Ohio Department of Health • School and Adolescent Health

Oral Assessment

Student's name	Date of birth / /
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The following services have been performed (please check all that apply)

<input type="checkbox"/> Examination	<input type="checkbox"/> Fluoride application	<input type="checkbox"/> Oral prophylaxis (cleaning)	<input type="checkbox"/> Prescription for fluoride supplement
<input type="checkbox"/> Orthodontic assessment	<input type="checkbox"/> Radiographs	<input type="checkbox"/> Dental sealant	<input type="checkbox"/> Treatment (restoration, pulp therapy)
<input type="checkbox"/> Other _____			

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

<input type="checkbox"/> Toothbrushing	<input type="checkbox"/> Flossing	<input type="checkbox"/> Dietary counseling	<input type="checkbox"/> Use of fluoride mouthrinse
<input type="checkbox"/> Other _____			

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

<input type="checkbox"/> All necessary preventive services have been performed. (Fluoride treatment, prophylaxis)
<input type="checkbox"/> No restorative services are required at this time.
<input type="checkbox"/> Further treatment is indicated.(See comments)
<input type="checkbox"/> Further appointments have been arranged. (Orthodontic, restorative)
<input type="checkbox"/> Routine recall visits recommended.

Comments

Dentist's signature	Print name	Phone ()
Address		Date / /
City	State	ZIP