

IMMUNIZATION REQUIREMENTS:

An Immunization record is required upon registration. Immunizations must be completed in accordance with Ohio law by the first day of school attendance. Included in your packet is a copy of current immunization requirements.

I. HEALTH CONDITIONS - Please check any that this child has had:

- | | |
|--|---|
| <input type="checkbox"/> Abnormal spinal curvature (scoliosis,etc.) | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Allergies or hayfever | <input type="checkbox"/> Kidney disease, type _____ |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Measles ("old fashioned" or "ten day") |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Meningitis or encephalitis |
| <input type="checkbox"/> Asthma or wheezing | <input type="checkbox"/> Multiple ear infections (3 or more) |
| <input type="checkbox"/> Bedwetting at night | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Behavior problem | <input type="checkbox"/> Near drowning or near-suffocation |
| <input type="checkbox"/> Birth or congenital malformation | <input type="checkbox"/> Nervous twitches or tics |
| <input type="checkbox"/> Cancer, type _____ | <input type="checkbox"/> Poisoning |
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Poor hearing |
| <input type="checkbox"/> Chronic diarrhea or constipation | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Concern about relationship with siblings or friends | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Cystic fibrosis | <input type="checkbox"/> Seizures or epilepsy |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Sickle cell disease |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Stool soiling |
| <input type="checkbox"/> Emotional problems | <input type="checkbox"/> Substance abuse (alcohol, drugs) |
| <input type="checkbox"/> Eye problems, poor vision | <input type="checkbox"/> Suicide attempt |
| <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Toothaches or dental infections |
| <input type="checkbox"/> Frequent skin infections | <input type="checkbox"/> Urinary tract infection |
| <input type="checkbox"/> Frequent sore throat infections | <input type="checkbox"/> Wetting during day |
| <input type="checkbox"/> Heart disease, type _____ | |

II. ALLERGIES - Please list and describe allergies or reactions to:

Medicine/drugs _____

Food/plants/animals/other _____

Recommended treatment if allergy is severe _____

III. INJURIES AND ILLNESSES - Please list any severe injuries or illnesses:

Injuries/Illnesses	Age of Child	If Hospitalized (check)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Does this child always wear seatbelts in cars? Yes ___ No ___

IV. ADDITIONAL INFORMATION:

What medications are given daily? _____

What medications are given frequently, but not daily? _____

This child is usually: very active ___ normally active ___ rather inactive ___

Do you have any concern about how your child gets along with other children?

Do you have other comments or concerns about this child's health, development, behavior, family or home life that you would like the school to be aware of? If yes, explain briefly _____

Completed by: _____

Relationship to child: _____