MILFORD
Exempted Village Schools

CENTRAL REGISTRATION
Kindergarten

Milford Exempted Village School District's Vision Statement
is to inspire and prepare our students to reach their fullest potential in a diverse and dynamic world.

Central Registration appointments can be scheduled by calling:
Mr. Jay Batterson
513-576-4178.

Milford Board of Education
777 Garfield Avenue
Milford, OH 45150

Please bring your child's completed enrollment packet along with other documentation required for enrollment to your appointment. Once the enrollment process is complete, your student's school will be contacted and you will be given a start date for your child.

If you have any questions regarding any of these forms or registration requirements, please contact the Central Registration Department at (513)576-4178.

MILFORD
Exempted Village Schools

KINDERGARTEN
REGISTRATION CHECKLIST

Student Name: _____ School: _____

DOCUMENTS REQUIRED FOR REGISTRATION

- ☐ Child's Original Birth Certificate or Passport (Bureau of Vital Statistics (614) 466-2531)
- ☐ Parent/Guardian Driver's License or State Issued ID Card
- ☐ Proof of Residency (Utility bill, lease/rental agreement*, deed, purchase contract)
  *Rental/Lease agreement must list names of all occupants
  - ☐ Residency Affidavit *(This affidavit is used when the parent/legal guardian and child are living in a domicile belonging to another person.)*
- ☐ Grade Documentation *(if applicable)*
- ☐ Custody Papers/Guardianship Papers *(if applicable)*
- ☐ Special Education paperwork - IEP/ETR *(if applicable)*
- ☐ Child's current immunization record

FORMS IN THE REGISTRATION PACKET

- ☐ Student Registration Form
- ☐ Records Request Form
- ☐ Emergency Medical Authorization Form
- ☐ Free and Reduced Meal Parent Disclosure Form *(if applicable)*
- ☐ Free and Reduced Meal Application *(if applicable)*
- ☐ Medical Forms
  - ☐ **ALL GRADES** - HEALTH HISTORY FORM (*completed by parent/guardian*)
  - ☐ **KINDERGARTEN** – PHYSICAL EXAMINATION FORM (*completed by physician*)
  - ☐ **KINDERGARTEN** – ORAL ASSESSMENT FORM (*completed by dentist*)
- ☐ Speech/Language Screening Permission Form

MILFORD
Exempted Village Schools

STUDENT REGISTRATION FORM

Office Use Only:

Student ID #_____

Enrollment Date:_____

School: _____ Grade____

_____ ☐ Male ☐ Female

Student's Legal Last Name Legal First Name Legal Middle Name Preferred Name

_____ _____

Date of Birth (mm/dd/yyyy) Place of Birth (City) (State) (Country)

Home Address: _____

Street Apt. # City Zip Code

_____ _____ _____

Home Phone Mother's Maiden Name Child's Native Language

Legal Guardianship

Are you the biological/adoptive parent(s) of the child? ☐ Yes ☐ No

If no, what is your relationship to the child? _____

Status of BIOLOGICAL/ADOPTIVE Parents: ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Single/Never married

If divorced, who has legal custody? ☐ Mother ☐ Father ☐ Shared Parenting

If foster/guardian, what district did the biological parent(s) reside in at the time you received custody? _____

If foster/guardian, please list Case Manager/Court Liaison: _____

Case manager/Court Liaison contact information: _____

Please complete information on father and mother, including contact numbers, regardless of marital status.

Circle: Father/Guardian/Foster Parent

☐ RESIDES here

Name: _____

Address: _____

City/State/Zip: _____

Home Phone: _____

Cell/Pager: _____

Email: _____

Name of Employer: _____

Business Phone: _____

Step-Father (if applicable): _____

Work Phone: _____

Cell/Pager: _____

Emergency Contact: _____

Relationship to child: _____

Phone: _____Work/Cell: _____

Circle: Mother/Guardian/Foster Parent

☐ RESIDES here

Name: _____

Address: _____

City/State/Zip: _____

Home Phone: _____

Cell/Pager: _____

Email: _____

Name of Employer: _____

Business Phone: _____

Step-Mother (if applicable): _____

Work Phone: _____

Cell/Pager: _____

Emergency Contact: _____

Relationship to child: _____

Phone: _____Work/Cell: _____

Siblings

Name	Age	Grade	Lives with…
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____

List any medical problems the student has: _____

_____

Citizenship/Ethnic Status

Citizenship Status: ☐ U.S. Citizen ☐ Non U.S. Citizen/Immigrant* ☐ Foreign Exchange Student

*Immigrant students are those who: are age 3 – 21, were not born in the United States, and have not attended one or more schools in any one or more of the states for more than three academic years.

Is the student of Hispanic/Latino heritage? ☐ Yes ☐ No

Persons of Mexican, Puerto Rican, Cuban, Central or South America, or other Spanish culture or origin regardless of race.

Is the student from one or more races using the following 5 racial/ethnic groups? **Check all that apply**.

Race/Ethnicity:	Definitions as defined by the Ohio Department of Education
☐ White	Persons having origins in any of the original peoples of Europe, North Africa, or the Middle East.
☐ Black/African American	Persons having origins in any of the Black racial groups of Africa.
☐ Asian	Persons having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian sub-continent. This area includes Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
☐ American Indian/ Alaskan Native	Persons having origins in any of the original peoples of North America and who maintain cultural identification through tribal affiliation or community recognition.
☐ Native Hawaiian or Other Pacific Islander	Persons having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

Special Services

Has your child ever attended Special Education classes? ☐ Yes ☐ No

Does your child have a 504 plan? ☐ Yes ☐ No

(Disability required only reasonable accommodations)

Has your child had an evaluation (M.F.E. : Multi-Factored Evaluation is an assessment of your child in all areas related to the suspected disability) in the past 3 years? ☐ Yes ☐ No

If yes, what is the date of the evaluation? _____

If yes, is there a current IEP? (Individualized Education Plan) ☐ Yes ☐ No

Has your child been identified as Gifted? ☐ Yes ☐ No

If yes, did your child receive Gifted Services at prior school? ☐ Yes ☐ No

If yes, grade of placement in Gifted Program? _____

If you answered "Yes" to any question in this section, please note any special needs information that may help us place your student:

_____

_____

Home Language Survey

Please complete this section if your child speaks a language other than English at home or was born outside of the United States.

Students Name: _____

Father's Nationality: _____ Mother's Nationality: _____

What languages can you (parent/guardian) speak?

Mother/Guardian:	Father/Guardian:
_____	_____
_____	_____

What language did your child speak when he/she first learned to talk? _____

What language does your child use most frequently at home? _____

What language do you use most frequently to speak to your child? _____

What language do the adults at home most often speak? _____

Does anyone in your home read English? ☐ Yes ☐ No

If yes, list name of person: Name _____ Relationship to child _____

How long has your child attended school in the United States? _____

What year did your child first attend school in the United States? _____

Did your child ever receive English instruction

before entering Milford Schools? ☐ Yes ☐ No

How often? _____ Where? _____

Where did your child last attend school? _____

How long was your child enrolled there? _____

Prior School History

Has your child ever been enrolled in Milford Schools? ☐ Yes ☐ No

If so, what year was he/she withdrawn? _____

LAST PUBLIC/PRIVATE SCHOOL ATTENDED:_____

School's address : _____

_____

School phone: _____ **School Fax**: _____

Is your child currently **expelled** or **suspended** from your previous district? ☐ Yes ☐ No

Parent/Guardian Signature

Required to complete Registration Form

I, the undersigned, do hereby state and declare under penalty of falsification (*) that I am the parent or legal guardian of the above named student and that this registration information is true and correct.

_____ _____

Parent/Guardian Signature Date

(*) Falsification under Ohio Revised Code section 2921.13 is a misdemeanor of the first degree punishable by a maximum of six (6) months imprisonment or a fine of $1,000 or both.

MILFORD EXEMPTED VILLAGE SCHOOL DISTRICT

IRN # 045500

STUDENT RECORDS REQUEST

Please release all appropriate past and present academic, discipline, medical, confidential and special education records (including psychological information, diagnostic summaries, IEP's, etc.) on the student named below. Records should be mailed/faxed to the school address indicated below.

STUDENT NAME	BIRTH DATE	GRADE
SIGNATURE OF PARENT/GUARDIAN	RELATIONSHIP	DATE

Name and address of school releasing records:

_____ Phone: _____

_____ Fax: _____

_____ Contact: _____

The following should be completed by the prior school, IF APPLICABLE:

The records for the above student CANNOT be released because (check all that apply):

☐ Fees due (Amount owed:_____) ☐ Grades incomplete ☐ No records available

☐ Books not returned (Titles): _____

If the student has been expelled, please include details of expulsion (reason and dates):_____

_____

_____ _____

Signature of person completing form **Date**

☐ **MCCORMICK ELEMENTARY**
IRN # 151936
751 Loveland-Miamiville Road
Loveland, OH 45140
Phone: (513) 575-0190
Fax: (513) 575-4019
Attn: Diane Saulnier

☐ **PATTISON ELEMENTARY**
IRN # 151951
5330 South Milford Road
Milford, OH 45150
Phone: (513) 831-6570
Fax: (513) 831-9693
Attn: Kathy Barrows

☐ **MILFORD JR. HIGH SCHOOL**
IRN # 024752
5735 Pleasant Hill Road
Milford, OH 45150
Phone: (513) 248-3444
Fax: (513) 248-3443
Attn: Connie Stevens

☐ **MEADOWVIEW ELEMENTARY**
IRN # 151944
5556 Mount Zion Road
Milford, OH 45150
Phone: (513) 831-9170
Fax: (513) 831-9340
Attn: Diane Moore

☐ **SEIPELT ELEMENTARY**
IRN # 030270
5684 Cromley Drive
Milford, OH 45150
Phone: (513) 831-9460
Fax: (513)248-5443
Attn: Marcia Dauw

☐ **MILFORD HIGH SCHOOL - NGC**
IRN # 024745
One Eagles Way
Milford, OH 45150
Phone: (513) 576-2278
Fax: (513) 576-2277
Attn: Pat Burke

☐ **MULBERRY ELEMENTARY**
IRN # 151928
5950 Buckwheat Road
Milford, OH 45150
Phone: (513) 722-3588
Fax: (513) 722-4584
Attn: Kathi Swift

☐ **BOYD E. SMITH ELEMENTARY**
IRN # 084970
1052 Jer-Les Drive
Milford, OH 45150
Phone: (513) 575-1643
Fax: (513) 575-2835
Attn: Jan Wulker

☐ **MILFORD HIGH SCHOOL**
IRN # 024745
One Eagles Way
Milford, OH 45150
Phone: (513) 576-2203
Fax: (513) 831-9714
Attn: Chris Duffy

EMERGENCY MEDICAL AUTHORIZATION FORM (2015-2016)

HAS YOUR INFORMATION CHANGED FROM THE PREVIOUS YEAR? ☐ YES ☐ NO

PURPOSE: To enable parents and guardians to authorize the provisions of emergency treatment or transportation for children who become ill or injured while under school authority, or during an emergency situation, when parents cannot be reached. ***NOTIFY THE SCHOOL IMMEDIATELY IF ANY INFORMATION CHANGES.*** (Ohio Revised Code 3313.712)
(Please print or type – AND SIGN FORM IN THE APPROPRIATE AREA on the reverse side).

TO THE PARENTS/GUARDIAN OF:

_____ ***STUDENT'S NAME*** _____ ***STUDENT ID***

_____ ***STREET ADDRESS*** _____ ***DATE OF BIRTH*** ***GENDER:*** ☐ Female ☐ Male

_____ ***CITY, STATE, ZIP*** _____ ***TELEPHONE #*** ***GRADE/HOMEROOM:*** _____

RESIDENTIAL/CUSTODIAL PARENT or LEGAL GUARDIAN:

Student LIVES with: (please check) and enter information below:

☐ **Father & Mother** ☐ **Mother ONLY** ☐ **Father ONLY** ☐ **Shared Parenting** ☐ **Foster Parent** ☐ **Other** _____

NAME	RELATIONSHIP	FULL ADDRESS (if different than student's)	HOME PHONE	CELL PHONE	WORK PHONE	E-MAIL ADDRESS

Additional space for e-mail address, if needed (indicate name): _____

List three (3) names of persons to be contacted in the EVENT OF AN EMERGENCY:

I understand that my child may be released to anyone on the list if ill, injured, or if an emergency occurs, and he/she must leave school.

NAME	RELATIONSHIP	HOME PHONE	CELL PHONE	WORK PHONE

MEDICAL PROBLEMS/ALLERGIES/SPECIAL NEEDS (Please check applicable box):

☐	Diabetes	☐	Bee or Insect Sting (bite)	☐	Hearing Impaired	☐	Emotional Problem	☐	Other
☐	Asthma	☐	Food Allergy	☐	Learning Disability	☐	Visually Impaired	☐	
☐	Seizures	☐	Medication Allergy	☐	Orthopedic	☐	History of Concussion	☐	

Please provide detailed information regarding any above checked items: _____

_____

Medication your child takes daily: _____

***** PLEASE REFER TO BACK PAGE FOR ADDITIONAL INFORMATION AND *REQUIRED SIGNATURES* *****

For educational purposes, special medical problems, physical impairments or other facts concerning your child's medical history may be shared with teachers or other support staff involved in the academic setting. If you ***DO NOT CONSENT*** for the sharing of this information, you are required to state this in writing and submit your statement with this form to your school administrator.

PART I OR II MUST BE COMPLETED - *(only complete Part I OR Part II)*

PART I: TO *GIVE* CONSENT ~

A. I hereby *GIVE CONSENT* for the following medical care providers and local hospital to be called:

Doctor: _____ **Phone:**_____

Dentist: _____ **Phone:** _____

Hospital: _____ **Phone:** _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above-named doctor, or in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

B. I authorize Milford Exempted Village School District to release any information which I have provided this school district concerning any medical history, including information regarding allergies, medications, physical condition, etc. of the student named above to any employee of the school district and/or volunteer providing medical service to the school district who has responsibility for such student while the student is at school, participating in a school sponsored function, or is being transported by the school.

_____

SIGNATURE OF PARENT/GUARDIAN **DATE**

***** Complete Part II *ONLY* if you have *NOT COMPLETED PART I* *****

PART II: *REFUSAL* to Give Consent ~

I *DO NOT GIVE* my consent for emergency medical treatment for my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action:

_____

_____

_____

_____

SIGNATURE OF PARENT/GUARDIAN **DATE**

TO BE COMPLETED BY PARENT/GUARDIAN

Ohio Department of Health • School and Adolescent Health

Health History

Student's name	Sex	Date of birth
	☐ Male ☐ Female	/ /

Family Health History Please list allergies, heart problems, diabetes, cancer or other serious health conditions.

Father
Mother
Brothers and Sisters

Birth and Developmental History ☐ No unusual birth or developmental history

Did the mother have any unusual physical or emotional illness during this pregnancy? ☐ Yes ☐ No

Was infant born full term? ☐ Yes ☐ No Did the infant have any sickness or problems? ☐ Yes ☐ No

Briefly explain illness or problems.

How does the child's development compare to other children, such as his or her brothers/sisters or playmates?

☐ About the same ☐ Delayed ☐ Advanced

Student Health Conditions

☐ **YES,** my child receives regular medical/health care for the following conditions: ☐ **NO** medical conditions

☐ Allergies	☐ Diabetes	☐ Seizure disorder
☐ Asthma	☐ Depression	☐ Sickle cell anemia
☐ ADD/ADHD	☐ Ear problem/hearing difficulty	☐ Skin conditions
☐ Autism	☐ Emotional concerns	☐ Speech problems
☐ Behavior concerns	☐ Headaches	☐ Traumatic brain injury
☐ Birth/congenital malformations	☐ Heart problems	☐ Vision problems (glasses, contacts)
☐ Bone/muscle/joint problems	☐ Hemophilia	☐ Other_____
☐ Blood problems	☐ Juvenile arthritis	☐ Other_____
☐ Bowel/bladder problems	☐ Lead poisoning	☐ Other_____
☐ Cancer	☐ Migraines	☐ Other_____
☐ Cystic fibrosis	☐ Neuromuscular disorder	☐ Other_____

Please explain any conditions above or any reasons for hospitalizations.

Please indicate any allergies your child may have.

Allergy type	Reaction	School restrictions or recommended actions
☐ Bee/Insect		
☐ Food		
☐ Medication		
☐ Other		

Health History continued

Please list any prescription and over the counter medication that your child takes on a regular basis.

Medication and dose	Time	Reason

Do any health and/or medical conditions require school restrictions, modifications, and/or intervention?

☐ Yes ☐ No If YES, please explain.

Does the student require any special procedures and/or treatments for their health condition(s)?

☐ Yes ☐ No If YES, please explain.

Please indicate any other information about your child's health or development that you think would be helpful for the school to know.

Form completed by	Relationship to student	Date
		/ /

KINDERGARTEN REGISTRATION - MEDICAL FORM CHECKLIST

The following medical forms are included in this packet.
Please refer to detailed information listed next to the form's name.

- ❒ **Physical Examination and Immunization Report**
  (completed by health care provider)

- ❒ **Oral Assessment**
  (completed by dentist)

Ohio State Law requires that all students meet the State's immunization requirements. The law also mandates that the immunization requirements be met within FIFTEEN days from the date of enrollment. Proof of immunization must be received by the clinic no later than the end of the school day on September 10, 2015 or the student will be excluded from school.

All Kindergarten students will be required to have written documentation of:

- **3 doses of Hepatitis B vaccine**
  The second dose must be administered at least 28 days after the first dose. The third dose must be administered at least 2 months after the second dose and at least 4 months after the first dose, and at least 6 months of age.

- **5 doses of DtaP, DTP, DT vaccine** or any combination, if the 4th dose was administered prior to the 4th birthday.

- **4 doses of Polio vaccine** of any combination of OPV or IPV. The final dose must be administered on or after the 4th birthday regardless of the number of previous doses.

- **2 doses of MMR** (Measles, Mumps, Rubella) vaccine
  The first dose must be administered on or after the child's first birthday and the second dose at least 28 days later.

- **2 dose of Varicella (Chicken Pox) vaccine**
  The first dose must be administered on or after the child's first birthday and the second dose at least 28 days later.

Immunization Summary for School Attendance
Ohio

VACCINES	*FALL 2015* IMMUNIZATIONS FOR SCHOOL ATTENDANCE
DTaP/DT **Tdap/Td** Diphtheria, Tetanus, Pertussis	**K** Four (4) or more of DTaP or DT, or any combination. If all four doses were given before the 4th birthday, a fifth (5) dose is required. If the fourth dose was administered at least six months after the third dose, and on or after the 4th birthday, a fifth (5) dose is not required.* **1-12** Four (4) or more of DTaP or DT, or any combination. Three doses of Td or a combination of Td and Tdap is the minimum acceptable for children age seven (7) and up. **Grades 7-12** One (1) dose of Tdap vaccine must be administered prior to entry.**
POLIO	**K-5** Three (3) or more doses of IPV. The FINAL dose must be administered on or after the 4th birthday regardless of the number of previous doses. If a combination of OPV and IPV was received, four (4) doses of either vaccine are required.*** **Grades 6-12** Three (3) or more doses of IPV or OPV. If the third dose of either series was received prior to the fourth birthday, a fourth (4) dose is required; If a combination of OPV and IPV was received, four (4) doses of either vaccine are required.
MMR Measles, Mumps, Rubella	**K-12** Two (2) doses of MMR. Dose 1 must be administered on or after the first birthday. The second dose must be administered at least 28 days after dose 1.
HEP B Hepatitis B	**K-12** Three (3) doses of Hepatitis B. The second dose must be administered at least 28 days after the first dose. The third dose must be given at least 16 weeks after the first dose and at least 8 weeks after the second dose. The last dose in the series (third or fourth dose), must not be administered before age 24 weeks.
Varicella (Chickenpox)	**K-5** Two (2) doses of varicella vaccine must be administered prior to entry. Dose 1 must be administered on or after the first birthday. The second dose should be administered at least three (3) months after dose one (1); however, if the second dose is administered at least 28 days after first dose, it is considered valid. **Grade 6-9** One (1) dose of varicella vaccine must be administered on or after the first birthday.

NOTES:

- Vaccine should be administered according to the most recent version of the *Recommended Immunization Schedules for Persons Aged 0 Through 18 Years* or the *Catch-up Immunization Schedule for Persons Aged 4 Months Through 18 Years Who Start Late or Who Are More Than 1 Month Behind*, as published by the Advisory Committee on Immunization Practices. Schedules are available for print or download at http://www.cdc.gov/vaccines/recs/schedules/default.htm.
- Vaccine doses administered ≤ 4 days before the minimum interval or age are valid (grace period). Doses administered ≥ 5 days earlier than the minimum interval or age are not valid doses and should be repeated as age-appropriate. If MMR and Varicella are not given on the same day, the doses must be separated by at least 28 days with no grace period.
- For additional information please refer to the Ohio Administrative Code 5101:2-12-37 for Child Care, Head Start, Pre-School and the Ohio Revised Code 3313.67 and 3313.671 for School Attendance and the ODH Director's Journal Entry (available at www.odh.ohio.gov, Immunization: Required Vaccines for Childcare and School). These documents list required and recommended immunizations and indicate exemptions to immunizations.
- Please contact the Ohio Department of Health Immunization Program at (800) 282-0546 or (614) 466-4643 with questions or concerns.

* Recommended DTaP or DT minimum intervals for Kindergarten students: four (4) weeks between doses 1-2 and 2-3; six (6) month minimum intervals between doses 3-4 and 4-5. If a fifth dose is administered prior to the 4th birthday, a sixth dose is recommended, but not required.

** Pupils who received one dose of Tdap as part of the initial series are not required to receive another dose. For students in 11th or 12th grades, one dose of Td (Tetanus and diphtheria) is acceptable. Tdap can be given regardless of the interval since the last Tetanus or diphtheria- toxoid containing vaccine. **DTaP given to patients age 7 or older can be counted as valid for the one-time Tdap dose.**

*** The final polio dose in the IPV series must be administered at age 4 or older with at least six months between the final and previous dose.

TO BE COMPLETED BY PHYSICIAN

Ohio Department of Health • School and Adolescent Health

Physical Examination

Student's name	Sex ☐ Male ☐ Female	Date of birth / /

Height	Weight	BMI percentile	BP

Screening Tests

Vision

Date performed / /

Distance Acuity	☐ R	☐ L
Muscle Balance	☐ Pass	☐ Fail
Stereopsis	☐ Pass	☐ Fail
Color	☐ Pass	☐ Fail
Child wears glasses?	☐ Yes	☐ No
Tested with glasses?	☐ Yes	☐ No
Referral made?	☐ Yes	☐ No

Hearing

Date performed / /

Pure Tone		
Right ear	☐ Pass	☐ Fail
Left ear	☐ Pass	☐ Fail
Child wears hearing aid?	☐ Yes	☐ No
Child under the care of a hearing specialist	☐ Yes	☐ No
Referral made?	☐ Yes	☐ No

Postural

Date performed / /

☐ No abnormality noted
☐ Screening not done
☐ Referral made
Comments
_____
_____
_____

Speech/Language

Speech assessment completed	☐ Yes	☐ No
Child has no discernible speech problem	☐ Yes	☐ No
Speech evaluation recommended	☐ Yes	☐ No

Child has possible problem with _____

Lead Poisoning

☐ Date _____ Type ☐ C ☐ V Results_____ µg/dL
☐ Date _____ Type ☐ C ☐ V Results_____ µg/dL

Tuberculin Test

Date_____ Type _____ Results_____

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

_____

Physical Examination Date of most recent examination / /

☐ Essentially normal ☐ Abnormalities as follows

_____

_____

Is this child able to participate fully in:

Classroom and academic activities	☐ Yes	☐ No	Physical education classes	☐ Yes	☐ No
Competition athletics	☐ Yes	☐ No	Contact and collision sports	☐ Yes	☐ No

If limitations are advised, please specify

_____

_____

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

_____

_____

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

HEA 4242 8/06

Ohio Department of Health • School and Adolescent Health

Immunization Report

Student's name	Sex	Date of birth
	☐ Male ☐ Female	/ /

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.
Please note the month, day, and year for each immunization should be on record.

Vaccine	**Record complete dates** (month, day, year) **of vaccine doses given**					
Diphtheria, Tetanus, Pertussis (DTP)						
DTaP, Tdap						
DT, Td						
Polio						
Hepatitis B (HBV)						
Measles, Mumps, Rubella (MMR)						
Varicella (Chickenpox)						
Hepatitis A						
Meningococcal (MCV4, MPSV4)						
Pneumococcal (PCV)						
Measles (Rubeola) only						
Rubella only						
Mumps only						
Haemophilus influenza Type b (Hib)						
Influenza						
Other						

This information was provided by ☐ Health Care Provider ☐ Parent/Guardian ☐ Other _____

Signature	Print name	Date
		/ /

HEA 4241 8/06

TO BE COMPLETED BY DENTIST

Ohio Department of Health • School and Adolescent Health

Oral Assessment

Student's name	Date of birth
	/ /

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

MILFORD EXEMPTED VILLAGE SCHOOL DISTRICT
777 Garfield Avenue ~ Milford, OH 45150
(513) 831-9690

* * * 2015 – 2016 SCHOOL YEAR * * *

Dear parent or guardian,

Please complete the information below, which gives the Milford Exempted Village School District permission to screen your child for speech and/or language concerns, if deemed necessary. Please note by signing your name, your child will not automatically be screened. He/she will **only** be screened if there is concern that your child's speech and/or language skills are having an adverse impact on educational performance. In the event that your child is referred for a screening, you will be notified by your child's classroom teacher. If you have any questions or concerns, please do not hesitate to contact us at any time.

Sincerely,

Jeanne Clough
District Speech-Language Pathologist

CHILD'S NAME: _____

TEACHER: _____

PARENT/GUARDIAN NAME: _____

PARENT/GUARDIAN SIGNATURE: _____