

# BIG WALNUT LOCAL SCHOOL DISTRICT

## MEDICAL AND IMMUNIZATION RECORD

ALL CHILDREN ENTERING KINDERGARTEN OR FIRST GRADE ARE REQUIRED TO HAVE A MEDICAL EXAMINATION AND REQUIRED IMMUNIZATIONS. (This information is confidential and becomes a part of the pupil's cumulative school record.)

NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ SCHOOL \_\_\_\_\_

STREET ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_

GENERAL APPEARANCE \_\_\_\_\_

<p><b>IMMUNIZATION REQUIREMENTS*</b> (LIST Month/Day/Year)</p> <p>DTaP/DTP/DT (1) _____ (2) _____ (3) _____ (4) _____ (5) _____</p> <p>POLIO VACCINE OPV/IPV (1) _____ (2) _____ (3) _____ (4) _____</p> <p>MMR (Measles, Mumps, Rubella) (1) _____ (2) _____</p> <p>HEPATITIS B (1) _____ (2) _____ (3) _____</p> <p>VARICELLA (Chickenpox) (1) _____ (2) _____</p> <p><b>OPTION IMMUNIZATIONS</b></p> <p>HIB (1) _____ (2) _____ (3) _____ (4) _____</p> <p><b>PAST HISTORY (Please check all that apply):</b></p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">Asthma _____</td> <td style="width: 50%;">Mumps _____</td> </tr> <tr> <td>Chickenpox _____</td> <td>Meningitis _____</td> </tr> <tr> <td>Diabetes _____</td> <td>Nephritis _____</td> </tr> <tr> <td>Encephalitis _____</td> <td>Scarlet Fever _____</td> </tr> <tr> <td>Epilepsy _____</td> <td>Tonsillitis _____</td> </tr> <tr> <td>Measles _____</td> <td>T.B. Contact _____</td> </tr> <tr> <td>Rubeola _____</td> <td>Whooping Cough _____</td> </tr> <tr> <td>Rubella _____</td> <td></td> </tr> <tr> <td>Other Serious Illness: _____</td> <td></td> </tr> </table>	Asthma _____	Mumps _____	Chickenpox _____	Meningitis _____	Diabetes _____	Nephritis _____	Encephalitis _____	Scarlet Fever _____	Epilepsy _____	Tonsillitis _____	Measles _____	T.B. Contact _____	Rubeola _____	Whooping Cough _____	Rubella _____		Other Serious Illness: _____		<p><b>PHYSICAL EXAMINATION</b></p> <p>DATE EXAMINED: _____</p> <p>HEIGHT: _____ WEIGHT: _____</p> <p>EYES: _____ VISUAL ACUITY: _____</p> <p>EARS: _____ HEARING ACUITY: _____</p> <p>NOSE: _____ THROAT (Tonsils): _____</p> <p>MOUTH (Teeth &amp; Muc. Memb.): _____</p> <p>NECK (Lymph Nodes &amp; Thyroid): _____</p> <p>HEART: _____</p> <p>LUNGS: _____</p> <p>ABDOMEN: _____</p> <p>GENTALIA: _____ HERNIA: _____</p> <p>EXTREMITIES: _____</p> <p>NERVOUS SYSTEM: _____</p> <p>SPEECH: _____</p> <p>URINALYSIS (If indicated): _____</p> <p>HEMOGLOBIN (If indicated): _____</p> <p>RECOMMENDATION FOR PHYSICAL ACTIVITY:</p> <p>FULL: _____ RESTRICTED: _____ NONE: _____</p> <p>REMARKS: _____</p> <p>_____</p> <p>_____</p>
Asthma _____	Mumps _____																		
Chickenpox _____	Meningitis _____																		
Diabetes _____	Nephritis _____																		
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Rubeola _____	Whooping Cough _____																		
Rubella _____																			
Other Serious Illness: _____																			

DATE: \_\_\_\_\_

PHYSICIAN'S SIGNATURE: \_\_\_\_\_

PHYSICIAN'S PRINTED NAME: \_\_\_\_\_

PHYSICIAN'S PRINTED ADDRESS: \_\_\_\_\_

Pupils enrolled in Pre-School through grade 12 are required to have WRITTEN PROOF ON FILE at their public or nonpublic school that they have been immunized against diphtheria, tetanus, pertussis, poliomyelitis, measles, mumps and rubella, and haemophilus influenza b (HIB) as well as Hepatitis B. HIB vaccines is required for Day Care, Pre-School and Head Start children only as set forth in Section 3301.53(A)(4) and 3313.671 of the Ohio Revised Code. Pupils who are not in compliance are to be excluded from school attendance NO LATER THAN FOURTEEN DAYS after admission.

Vaccines	Fall 2013 Immunization Requirements for Child Care/Head Start and Pre-Schools	Fall 2013 Immunization Requirements for School	Dates of Immunization
<b>DTaP/DTP/DT</b> Diphtheria, Tetanus, Pertussis	4 doses of DTaP, DTP or DT or any combination.	<b>Kindergarten</b> 4 or more of DTaP or DT, or any combination. If all 4 doses were given before the 4 <sup>th</sup> birthday, a 5 <sup>th</sup> dose is required. If the 4 <sup>th</sup> dose was administered at least six months after the 3 <sup>rd</sup> dose, and on or after the 4 <sup>th</sup> birthday, a 5 <sup>th</sup> dose is not required.*  <b>Grades 1-12</b> 4 or more off DTaP or DT, or any combination. 3 doses of Td or a combination of Td and Tdap is the minimum acceptable for children age 7 and up.  <b>Grades 7-10</b> 1 dose of Tdap or Td vaccine must be administered prior to entry.**	#1 ___/___/___ #2 ___/___/___ #3 ___/___/___ #4 ___/___/___ #5 ___/___/___
<b>Polio</b>	3 doses of OPV or IPV or any combination of OPV or IPV.	<b>K-3</b> 3 or more doses of IPV. The FINAL dose must be administered on or after the 4 <sup>th</sup> birthday regardless of the number of previous doses. If a combination of OPV and IPV was received, 4 doses of either vaccine are required.***  <b>Grades 4-12</b> 3 or more doses of IPV or OPV. If the 3 <sup>rd</sup> dose of either series was received prior to the 4 <sup>th</sup> birthday, a 4 <sup>th</sup> dose is required; If a combination of OPV and IPV was received, 4 doses of either vaccine are required.	#1 ___/___/___ #2 ___/___/___ #3 ___/___/___ #4 ___/___/___
<b>MMR</b> Measles, Mumps, Rubella	1 dose of MMR administered on or after the 1st birthday.	<b>K-12</b> 2 doses of MMR. Dose 1 must be administered on or after the 1st birthday. The 2nd dose must be administered at least 28 days after dose 1.	#1 ___/___/___ #2 ___/___/___
<b>Hib</b> Haemophilus Influenza Type b	3 or 4 doses depending on the vaccine type and the age when the child began the 1st dose and the last dose is after 12 months or 1 dose if given on or after 15 months of age.	<b>None</b>	#1 ___/___/___ #2 ___/___/___ #3 ___/___/___ #4 ___/___/___
<b>HEP B</b> Hepatitis B	3 doses of hepatitis B	<b>K-12</b> 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.	#1 ___/___/___ #2 ___/___/___ #3 ___/___/___
<b>Varicella</b> (Chickenpox)	1 dose of Varicella administered on or after the first birthday.	<b>K-3</b> 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 months after dose one; however, if the second dose is administered at least 28 days after first dose, it is considered valid.  <b>Grade 4-7</b> 1 dose of Varicella vaccine must be administered on or after the first birthday.	#1 ___/___/___ #2 ___/___/___

Notes:

- \*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 4<sup>th</sup> birthday, a sixth dose is recommended, but not required.
- Vaccine does 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 7<sup>th</sup> -10<sup>th</sup> grade: If one dose of Tdap was part of the initial series, another dose of Tdap will not be required. For students in 9<sup>th</sup> or 10<sup>th</sup> grade, 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.
- \*\*\*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.

The schools have been directed by the Ohio Department of Health and the Ohio Department of Education to exclude from school those students not in compliance with these minimum requirements. Unless this matter is resolved within fourteen (14) days your child will be excluded from school as of that date. If you care to discuss your child's immunization needs or if you need help in obtaining immunizations, please contact the Delaware City-County Health Department at (740) 368-1700.

