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 **FRIDAY, SEPTEMBER 9, 2016** or your child **WILL be excluded from school starting Monday, September 12, 2016.** 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

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	☐ 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?

_____

_____

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
	/ /

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