

**STUDENT HEALTH RECORD
KETTERING CITY SCHOOL DISTRICT
HEALTH SERVICES - STUDENT SERVICES**

PARENTS: Complete Section I

SECTION I:

Date _____

Student's Name _____

Address _____

ZIP CODE _____

Student's Birthdate _____ Sex _____ Name of School _____

Name of Parent(s) or Guardian _____

Check the disease(s) your child has or has had:

Asthma _____ Diabetes _____ ADD _____ ADHD _____

Heart Disease _____ Chicken Pox _____ Cancer _____ Tuberculosis _____

Seizure Disorder _____ Other _____

Is your child on any medication? Yes _____ No _____

Please name medication and reason it's taken _____

Does student have a physical disability and/or limitation? Yes _____ No _____

Explain _____

Does student have any allergies? Yes _____ No _____

List allergies: _____

Would you say student is (check one) very active _____ average _____ quiet _____

Please state any health problems student may have that would be important for the school to know:

EXAMINING DENTIST: Complete Section II

SECTION II: Date of Examination _____

1. At this time, child has no apparent dental defects _____
2. Child is under regular dental care _____
3. Appointments have been made for correction of dental defects _____

Dentist Signature

(Have licensed medical provider complete other side)

STUDENT NAME: _____

Student No. _____

EXAMINING LICENSED MEDICAL PROVIDER:

Complete Section III

1. At this time, child has no apparent physical limitations. (check) _____
2. Prior history and present examination shows child has physical condition(s) and/or limitation(s) as listed below to which school personnel should be alerted: (describe condition and /or degree of limitations) _____

3. Comments: _____

IMMUNIZATION RECORD: (To be completed by licensed medical provider/clinic) Day, month, year for each dose required. (Immunizations required by Sections of the Ohio Revised Code. Revisions effective beginning with the KG class of 1999-2000.)

DPT (DTaP, DT, Td) Dates	_____	_____	_____	_____	_____
	1 st	2 nd	3 rd	4 th	5 th

Polio Dates (Specify OPV or IPV)

OPV	_____	_____	_____	_____	_____
	1 st	2 nd	3 rd	4 th	5 th
IPV	_____	_____	_____	_____	_____
	1 st	2 nd	3 rd	4 th	5 th

MMR-Dates	_____	_____	Chicken Pox-Dates	_____	_____
	1 st	2 nd			

HEP-B – Dates _____

Mantoux PPD-Date _____ Negative _____ Positive _____

Date of Examination _____

Print Licensed Medical Provider Name _____

Address _____

Phone _____

Licensed Medical Provider or Clinic Signature