Dayton SMART Elementary

Record de Examen de Salud Escolar – Historia de Salud y Vacunaciones

PARTE 1- QUE LOS PADRES TIENEN QUE COMPLETAR

Nombre del niño/a _____

Apellido Nombre Segundo Nombre

A. ALERGIAS– POR FAVOR DESCRIBA TODAS LAS ALERGIAS Y REACCIONES DEL NIÑO/A:

Medicinas/Medicamentos: _____

Comida/Plantas/Animales/Otros: _____

Tratamientos/ recomendados en caso que la alergia sea severa: _____

B. HERIDAS Y ENFERMEDADES – POR FAVOR DESCRIBA CUALQUIER HERIDA Y ENFERMEDAD:

Heridas / enfermedad	Edad del niño/a	Fue hospitalizado?
1-		
2-		
3-		

C. Información Adicional:

Que medicamento toma el niño/a diario? _____

_____

Que medicamento toma el niño/a seguido ? _____

_____

Normalmente este niño/a es: ☐ Muy activo ☐ Normal activo ☐ Pocas veces activo

Algún familiar en casa tiene, tuberculosis, diabetes o otra enfermedad seria? _____

ALGO MÁS ACERCA DEL NINO/A QUE LA ESCUELA/MAESTROS NESECITAN SABER PARA PODER AYUDAR AL ESTUDIANTE? _____

_____

D. Información acerca de otros medicamentos :

_____

_____

_____

_____

E. Firma del padre/ Madre/Guardián:

_____ _____

Firma del padre/madre/guardián *Fecha de la firma*

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PART II – TO BE COMPLETED BY PHYSICIAN PRIOR TO SCHOOL ADMISSION

Print Student's Last Name _____ First _____ M.I. _____ Date of Birth _____

F. IMMUNIZATION RECORD: Minimum requirements are listed for each vaccine. Those marked with an (*) are required by the Ohio Department of Health; all others are recommended by the Centers for Disease Control and Prevention.

RECOMMENDED IMMUNIZATION (ENTER MONTH, DAY AND YEAR)					
VACCINES	**DOSE 1**	**DOSE 2**	**DOSE 3**	**DOSE 4**	**DOSE 5**
Diphtheria (DTaP), Tetanus (DT/Tdap/Td), Pertussis*					
DTap (7th – 9th grade only) *					
Hepatitis B (Hep B) *					
Measles, Mumps, Rubella (MMR) *					
Polio (IPV or OPV) *					
Varicella (Chicken Pox) * [2 doses K-2; 1 dose 3 – 6]					
Influenza					
Pneumococcal Conjugate (PCV)					
Meningococcal					
Hepatitis A					
Haemophilus Influenza – type b (HIB, preschool only)					
Human Papillomavirus (Gardasil)					

Recommended Assessments/ Screenings:

Vision: ❍ Yes ❍ No Date: _____ Hearing: ❍ Yes ❍ No Date: _____

Dental: ❍ Yes ❍ No Date: _____ Lead: ❍ Yes ❍ No Date: _____

BMI: ❍ Yes ❍ No Date: _____ Other: ❍ Yes ❍ No Date: _____

I have examined this child and found that he/she is in suitable condition for participation in school.
The child has had the age appropriate immunizations as recommended by the Ohio Department of Health.
My office has entered the child's immunization record as noted above or attached a printed record of the immunizations or found that this child should be exempt from immunizations for the following reasons:

_____

_____

List any limitations or health conditions for this child (including allergies, daily medication and dietary restrictions):

_____

_____

_____

G. SIGNATURE OF PHYSICIAN/PHYSICIAN'S ASSISTANT/ADVANCED PRACTICE NURSE:

_____ Date of Examination _____

Printed Name _____

Office Address _____

City/State/Zip _____ Office Phone: _____