Dayton SMART Elementary
School Health Examination Record – Health & Immunization History
PART I - To Be Completed BY Parent / Guardian

Chi	ld's Name								
	(Prin	nt) Last	First	Middle					
۹. <u>ج</u>	ALLERGIES – PLEASE LIST	AND DESCRIBE ALLERGIES (	OR REACTIONS TO:						
	Medicines/Drugs:								
	Foods/Plants/Animals/Ot	hor:							
		-							
	Recommended treatmen	t is allergy is severe:							
В. <u>I</u> I	INJURIES AND ILLNESSES - PLEASE LIST ANY SEVER INJURIES OR ILLNESSES:								
	Injury / Illness		Age of Child	Check if hospitalized					
C. A	ADDITIONAL INFORMATION	ON:							
<u>-</u>	What medications are given								
	vvnat medications are gr								
	What medications are given	en frequently, not daily?							
	This child is usually:	very active	normally active	rather inactive					
	Does any relative or anyone in the home have tuberculosis, diabetes or other serious illness?								
	Is there anything about your child that the school/teacher needs to know to understand him/her better?								
<b>.</b>		CAL INFORMATION.							
D. <u>C</u>	OTHER PERTINENT MED	CAL INFORMATION:							
E. <u>S</u>	SIGNATURE OF PARENT	GUARDIAN:							
	Signature of Parent/Guardian			Date Signed					
	•			•					

Dayton SMART Elementary
School Health Examination Record – Health & Immunization History
PART II – TO BE COMPLETED BY PHYSICIAN PRIOR TO SCHOOL ADMISSION

Print Student's Last Name	First	M.I.		Date of B	irth
MMUNIZATION RECORD: Minimum requirem required by the Ohio Department of Health; all other					
Prevention.		,			
RECOMMENDED IMMU			ND YEAR)		
VACCINES	DOSE 1	DOSE 2	DOSE 3	DOSE 4	DOSI
Diphtheria (DTaP), Tetanus (DT/Tdap/Td), Pertussis*					
DTap (7 <sup>th</sup> – 9 <sup>th</sup> 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)					
Dental: O Yes O No Date:				Date:	
BMI: • Yes • No Date:	Oth	er: O Ye	es O No	Date:	
have examined this child and found that he/she is in surfice child has had the age appropriate immunizations as My office has entered the child's immunization record as that this child should be exempt from immunizations for List any limitations or health conditions for this child	s recommended b s noted above or the following reas	y the Ohio Depo attached a print ons:	artment of Hea	ne immunizatio	
	a (morading and	.g.oo, daily iii		z diotary root	
SIGNATURE of Physician/Physician's Assis	STANT/ADVANC	ED PRACTICE			
Printed Name	-				
Office Address		-			
City/State/7in		Office	DL		