

RICHMOND HEIGHTS LOCAL SCHOOL DISTRICT



REGISTRATION PACKET

"It's a New Day for the Richmond Heights Way"

447 Richmond Road, Richmond Heights Ohio 44143

www.richmondheightsschools.org

RICHMOND HEIGHTS LOCAL SCHOOLS

447 RICHMOND RD. RICHMOND HTS., OHIO 44143 PHONE: 216-692-0086 FAX: 216-692-8487

"It's the Dawning of a New Day"

Welcome New Families and Partners in Education

We are so excited to welcome you to Spartan Nation and want to ensure that your child has a smooth transition to Richmond Heights Local Schools.

In order to meet that goal we will need ALL documents noted on the enrollment package. Therefore we strongly recommend you come prepared with all information to support a complete enrollment and a smooth transition. Upon a completed enrollment package, your child/children will begin school in 48 hours. This process is to allow the guidance counselor opportunity to schedule accordingly and the review of any documents that indicate exceptionalism and proper placement. Some pertinent documents that support a smooth transition that can be obtained from the previous school district are: transcripts, 504, IEP's and ETR's.

If you are unable to provide ALL documents at the time of enrollment, your child/children cannot begin school at Richmond Heights Local Schools until the registrar's office is in receipt of a complete enrollment package. Please refer to the enrollment package for the required documents.

If you have any questions of clarification, please feel free to contact me at askew.kelly@richmondheightsschools.org.

Thank you and Welcome to Spartan Nation,

Kelly Askew-Tucker

Kelly Askew-Tucker
Director of Educational Services
216-692-0086 ext.571228



RICHMOND HEIGHTS LOCAL SCHOOLS

447 RICHMOND RD, RICHMOND HTS., OH 44143 PHONE 216-692-0086 FAX 216-692-8487

REGISTRATION PACKET CHECK LIST

Parents, legal custodians or guardians must register their children **by appointment only** at the Board of Education Office. To schedule an appointment, please call **Ms. Bendes** at **(216) 692-7395**. Use the checklist below for the registration process to move quickly. Please supply the district with the following documents:

1. ___ A current **Driver's License** or current **State ID** of the adult registering the student.
2. ___ Completed registration forms (attached).
3. ___ **Original or certified** copy of child's **Birth Certificate**.
4. ___ Child's **Social Security Card** of proof of number.
5. ___ Stamped, certified copy of **court order** establishing custody or guardianship (if applicable).
6. ___ **Notarized Residency Affidavit**.
7. ___ **Lease, Current Mortgage Statement, Deed or Current Tax Bill**
8. ___ Child's complete **Immunization records** signed by your physician or from previous school.
9. ___ **Records** from previous school such as, **Transcripts or last grade report, IEP and ETR, 504**.
10. ___ **Withdrawal Form** from previous school.

As the parent or legal guardian of the children being registered, you have a continuing responsibility to inform the superintendent of schools of any change of residence or legal custody. Regarding legal custody or guardianship, a court of jurisdiction must award it before a student will be allowed to enroll in the Richmond Heights Local School District.

The Richmond Heights Schools attendance officer will confirm the accuracy of information provided during the registration process by making home visits to all new students.

I have read the above enrollment procedures, understand them and will abide by them. I will notify the superintendent of schools of any changes that may occur.

Signature _____ Date _____



RICHMOND HEIGHTS LOCAL SCHOOL DISTRICT

RESIDENCY AND CUSTODY AFFIDAVIT



For the purpose of establishing school residence and custody (To be completed by parent or legal guardian)

SIGN ONLY AFTER CAREFULLY READING AND SIGNING IN THE PRESENCE OF A NOTARY

THE UNDERSIGNED, FIRST BEING DULY SWORN ACCORDING TO LAW, STATE THAT:

I, _____, certify that I am the custodial parent/legal guardian of _____
(Parent's or Legal Guardian's Full Name) (Student's Name)

and that I have established residency at _____
(Street Number, Name, Apt. #) (City) (State) (Zip Code)

Date of Occupancy: _____ Lease End Date (if applicable): _____

I, _____, certify that I am a resident of the above residence located within **Richmond Heights Local School District**. The registrar has explained to me that legal residency is determined by certain conditions, among them are that mail delivery, voting residence, and payroll city tax deductions are based on the **Richmond Heights Local School District** address and also, that the residence where meals are taken, and where the resident parent sleeps must be the **Richmond Heights Local School District/Richmond Heights** residence. (Photo identification, such as an Ohio Driver's License with your most recent address, is required for identification)

List the names of ALL people, both adults and children, who reside at the above address. Also, please indicate their school (if applicable) and "status" (i.e., homeowner, lessee, renter, parent, guardian, student, preschooler, grandparent, etc.) Attach a separate piece of paper, if needed.

Last Name	First Name	School (If Applicable)	Last Name	First Name	School (If Applicable)
Last Name	First Name	School (If Applicable)	Last Name	First Name	School (If Applicable)
Last Name	First Name	School (If Applicable)	Last Name	First Name	School (If Applicable)

Please read each statement and then place your initials to the left of the statement.

- _____ I/we certify that the information provided in this document and registration packet is true and no information has been withheld, concealed, or misrepresented for the purpose of circumventing the school attendance laws of the State of Ohio in order to enroll named students in the **Richmond Heights Local School District**.
- _____ I/we understand that I/we are responsible for informing school officials of any change(s) in the residence of any parent, legal guardian, or other responsible adult. If I change my present address to another address that is within the **Richmond Heights Local School District**, I will **immediately** file another residency and custody affidavit with the Board of Education of the **Richmond Heights Local School District**. I further understand that if the above noted address ceases to be my legal residence and my new residence is outside the boundaries of the **Richmond Heights Local School District**, I will withdraw my child(ren) from the district and will enroll my child(ren) in the new district of residence.
- _____ I/we are also responsible for informing school officials of any changes to the legal custody or guardianship of the child(ren).
- _____ I/we have provided the **Richmond Heights Local School District** with an official copy of any and all current court orders from the Domestic Relations, Juvenile, Probate or any other court which has exercised jurisdiction over the custody or residency of the children being enrolled as per Ohio Revised Code 3313.672.
- _____ I/we acknowledge the student who is being registered has not been expelled or excluded from any other school pursuant to O.R.C. Sections 3301.121 and 3313.662.
- _____ I/we understand that if the student attends school while not being eligible to do so tuition free, the student and all responsible parties will be liable for tuition at a rate set by the Ohio Department of Education according to the Ohio Revised Code 3317.08, and related costs, and the student will immediately be withdrawn from the **Richmond Heights Local School District**.
- _____ I/we understand that the **Richmond Heights Local School District** may use whatever legal means it has at its disposal to verify my residency. I/we hereby waive my rights to confidentiality of information relative to my/our residence and give permission to the **Richmond Heights Local School District**, the City Tax Administrator, and the Regional Income Tax Agency (RITA) to release information such as name, social security number, and current and former addresses to confirm or deny my residency for the current or prior years.
- _____ **Be sure you have read this statement carefully before you initial. Giving false information under oath is punishable as a criminal offense under the Ohio Revised Code 2921.13 and 2921.21, a misdemeanor of the first degree with a maximum fine of \$1,000 and/or a jail term of six months. In cooperation with the City Prosecutors, each violation may be thoroughly and vigorously prosecuted.**

Signature(s) – MUST BE SIGNED IN FRONT OF A NOTARY IN ORDER TO BE NOTARIZED. DO NOT SIGN IN ADVANCE.

Parent/Legal Guardian/Custodian: _____
Student 18 years of age or older: _____

County of Cuyahoga

)SS

State of Ohio)

Before me, a Notary Public of the State of Ohio, came the above-named who said that he/she/they did understand the statements set forth above and did adopt said statements and the information, herein as his/her/their own, as true to the best of his/her knowledge of the consequences and penalties of falsification, and did affix his/her signature in my presence,

This _____ day of _____, 20____

Notary Public



RICHMOND HEIGHTS LOCAL SCHOOL DISTRICT

STUDENT REGISTRATION FORM



Student Name	Last Name	First Name	Middle Name	Entry Grade
Social Security # <small>(optional)</small>	- -	Birth Date	Month / Day /	Year
Student Home Address	Number	Street	City	Zip Code Up <input type="checkbox"/> Down <input type="checkbox"/> Apt. #
Parent/Guardian	Name		Phone Number	
Previous school attended <small>Include homeschooling</small>	Name of School		School District	City State

Is this student Hispanic/Latino? <input type="checkbox"/> No, not Hispanic/Latino <input type="checkbox"/> Yes, Hispanic/Latino	Race <small>(choose one or more)</small> <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander How Identified:
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Citizenship <input type="checkbox"/> Dual National <input type="checkbox"/> Non-Resident Alien <input type="checkbox"/> Resident Alien <input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Other please name:

Birthplace	City	State	Country	Native / Primary Language <input type="checkbox"/> English <input type="checkbox"/> Other please name:
-------------------	------	-------	---------	---

Student Lives With (check all that apply) <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Step-Parent <input type="checkbox"/> Other (explain):	<input type="checkbox"/> Guardian <input type="checkbox"/> Spouse <input type="checkbox"/> Self
Legal Custody (check all that apply) <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Foster Parent Court Journal Entry: (/ /) County: _____ District Bearing Cost(for Foster Children only):	<input type="checkbox"/> Guardian <input type="checkbox"/> CCDCFS <input type="checkbox"/> Other (explain): <input type="checkbox"/> Probate Court <input type="checkbox"/> Juvenile Court Restrictions: _____

Is the child in gifted or Advanced Placement?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, describe services:
Does the child have a 504 plan?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, describe services:
Has the child ever had an IEP?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, list year of most recent evaluation:
If yes, do you have a copy of the IEP?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, indicate program:
Is the child suspended?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, from what district?
Is the child expelled?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, from what district? End Date: _____

I do not consent to the release of email, home address, and home phone number for outreach purposes

Daycare/Preschool/Kindergarten Questionnaire

Has your child been in a previous school setting: Yes No

If so, please name school(s): _____ Address _____

City _____ State _____ Phone Number _____

Permission to Contact: Yes No

Parent/Guardian Signature: _____ Date: _____

PARENT(S) / GUARDIAN INFORMATION

STUDENT NAME:

Mother		<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Separated	<input type="checkbox"/> Remarried	<input type="checkbox"/> Deceased
<input type="checkbox"/> Residential <input type="checkbox"/> Non-Residential		Dual Mailing: <input type="checkbox"/> Yes <input type="checkbox"/> No		Last Name		First Name	
Address		Number	Street	City		Zip Code	
Workplace				Email			
Home Phone			Work Phone		Cellular Phone		

Father		<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Separated	<input type="checkbox"/> Remarried	<input type="checkbox"/> Deceased
<input type="checkbox"/> Residential <input type="checkbox"/> Non-Residential		Dual Mailing: <input type="checkbox"/> Yes <input type="checkbox"/> No		Last Name		First Name	
Address		Number	Street	City		Zip Code	
Workplace				Email			
Home Phone			Work Phone		Cellular Phone		

<input type="checkbox"/> Legal Guardian	<input type="checkbox"/> Step Parent	<input type="checkbox"/> Foster Parent	<input type="checkbox"/> Other:				
Last Name		First Name					
Address		Number	Street	City		Zip Code	
Workplace				Email			
Home Phone			Work Phone		Cellular Phone		
Social Worker (If Applicable):							

<input type="checkbox"/> Legal Guardian	<input type="checkbox"/> Step Parent	<input type="checkbox"/> Foster Parent	<input type="checkbox"/> Other:				
Last Name		First Name					
Address		Number	Street	City		Zip Code	
Workplace				Email			
Home Phone			Work Phone		Cellular Phone		
Social Worker (If Applicable):							

EMERGENCY CONTACT INFORMATION

Name	Relationship	Name	Relationship
Telephone		Telephone	
Address		Address	
Email		Email	

PLEASE LIST ALL OTHER CHILDREN UNDER THE AGE OF 22 WHO LIVE AT THE HOME ADDRESS

Name	Grade	Date of Birth	Gender	Relationship To Student

I hereby certify, under penalty of perjury, that all of the information that I have given is correct in all respects to the best of my knowledge.
 Date: _____ Parent/Legal Guardian/Independent Student: _____

Date:	Information Verified By: _____
-------	--------------------------------



RICHMOND HEIGHTS LOCAL SCHOOLS

REQUEST FOR TRANSFER OF STUDENT RECORDS

RECORDS OF: _____
Student *Grade* *Date of Birth*

Former Address *City, State, Zip, Country*

RELEASED FROM: _____
School/Agency

Address

City, State, Zip

Phone _____ Fax _____

RELEASE TO: **Richmond Heights Board of Education**
Registrar
447 Richmond Road
Richmond Heights, OH 44143
Phone: 216/692-7395
Fax: 216/692-8487
Email: bendes.kathy@richmondheightsschools.org
1st Day of Admission _____

Please include any or all listed below:

- ____ Transcripts/Academic Grades
- ____ Grades to Date of Withdrawal
- ____ Standardized Test Scores
- ____ Individual Career Plan
- ____ Health and Immunization Records
- ____ IEP/ETR
- ____ 504 Plan
- ____ Other, please specify _____

I acknowledge notification of this transfer of records as required by the Family Educational Rights and Privacy Act of 1974 and I understand that I have the right to receive a copy, if requested, and have an opportunity for a hearing to challenge the content of the records. I understand that the information transferred will be treated in a confidential manner and will not be transmitted to a third party without my consent.

Signature *Relationship* *Date*



Richmond Heights Local Schools

Emergency Medical Authorization

To enable parents and guardians to provide necessary information and to authorize the provision of emergency treatment for a student who becomes ill or is injured while under school authority.

Student Name _____
Last First Middle Birth Date

Home Address _____ **Apt.** _____

Primary Phone (____) _____ **E-mail** _____

Parent(s) or Guardian with whom student lives:

_____/_____
Name / Relation to student Name / Relation to student

Cell Phone (____) _____ **Cell Phone** (____) _____

Daytime (____) _____ **Daytime** (____) _____

Non-Residential Parent (If Applicable)

Name / Relationship to Student Primary Phone

Address Apt. City State Zip Code

Is there a court order which limits / prohibits non-custodial parent contact? Yes No
If yes is marked, parent must contact the office and provide legal documentation.

Transportation

Check all that applies: Bus to school _____ Bus from school _____ Car rider _____ Walk _____

* If your child does not go home after school, please list where the child goes, on what days, and phone number:

Name / Agency Phone Number **M T W T H F**
Circle Days

Note: Requests to change normal transportation MUST be made in writing.

List the person(s) who will care for your child in the event that reasonable attempts to contact parent(s) have been unsuccessful. List contacts in the order in which you prefer them to be called.

1. _____ (____) _____
Name / Relationship to Student Primary Phone
2. _____ (____) _____
Name / Relationship to Student Primary Phone
3. _____ (____) _____
Name / Relationship to Student Primary Phone

Please include name of an older sibling who is authorized to pick up student in the event of a disaster.

Grade _____

Information Concerning Student's Health – Please print

Medical History: _____

Allergies (insect, food, medications, etc.): _____

Physical impairments that limit mobility: _____

Medications taken (including dosage and times given): _____

****Please note: If your child would need to take any medication during a 24-hour period of "sheltering in place", please contact the school nurse to discuss this matter confidentially.**

Describe any **critical medical information** the bus driver should be aware of when transporting this student:

To Grant Consent

I grant consent, in the event that reasonable attempts to contact me have been unsuccessful, (1) for the administration of any treatment deemed necessary by the named doctors:

Dr. _____ Phone Number (____) _____
Preferred Physician

Dr. _____ Phone Number (____) _____
Preferred Dentist

or in the event the designated preferred practitioner is not available, by another licensed physician or dentist.

(2) the transfer of the child to (preferred hospital) _____, or any hospital reasonably accessible. This authorization does not cover major surgery, unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Signature of Parent / Guardian

Date

Refusal to Grant Consent

I refuse to grant consent for emergency medical treatment of my child. In the event of illness or injury requiring medical treatment, I wish the school authorities to take the following action:

Signature of Parent / Guardian

Date

I understand that I am responsible for keeping ALL information current and correct.

Appendix A: Language Usage Survey

Parents and Guardians: Please only complete this page of the survey. The back of this form will be completed by the school. A completed language usage survey is required for all students upon enrollment in Ohio schools. This information will tell school staff if they need to check your child's proficiency in English. Answers to these questions ensure your child receives the education services to succeed in school. The information is not used to identify immigration status.

Student Name: (First Name and Last Name) _____		Student Date of Birth: (mm/dd/yyyy) _____	
Communication Preferences Indicate your language preference so we can provide an interpreter or translated documents at no cost when you need them. All parents have the right to information about their child's education in a language they understand.		1. In what language(s) would your family prefer to communicate with the school? _____	
Language Background Information about your child's language background helps us identify students who qualify for support to develop the language skills necessary for success in school. Testing may be necessary to determine if language supports are needed.		2. What language did your child learn first? _____ 3. What language does your child use the most at home? _____ 4. What languages are used in your home? _____	
Prior Education Responses about your child's birth country and previous education give us information about the knowledge and skills your child is bringing to school and may enable the school to receive additional funding to support your child.		5. In what country was your child born? _____ 6. Has your child ever received formal education outside of the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many years/months? _____ If yes, what was the language of instruction? _____ 7. Has your child attended school in the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when did your child first attend a school in the United States? _____ / _____ / _____ Month Day Year	
Additional Information Please share additional information to help us understand your child's language experiences and educational background.		_____	
Parent/Guardian First Name: _____		Parent/Guardian Last Name: _____	
Parent/Guardian Signature: _____		Today's Date: (mm/dd/yyyy) _____	

Thank you for providing the information above. Contact your school or district office if you have questions about this form or about services available at your child's school. Translated information about schools' civil rights obligations to English learner students and limited English proficient parents can be found here: <https://www2.ed.gov/about/offices/list/ocr/ellresources.html>



Immunization Summary for School Attendance - Ohio

VACCINES	FALL 2019 IMMUNIZATIONS FOR SCHOOL ATTENDANCE
DTaP/DT Tdap/Td Diphtheria, Tetanus, Pertussis	<p><u>Kindergarten</u> Four (4) or more doses of DTaP or DT, or any combination. If all four doses were given before the 4th birthday, a fifth (5) dose is required. If the fourth dose was administered at least six months after the third dose, and on or after the 4th birthday, a fifth (5) dose is not required. *</p> <p><u>1-12</u> Four (4) or more doses of DTaP or DT, or any combination. Three doses of Td or a combination of Td and Tdap is the minimum acceptable for children age seven (7) and up.</p> <p><u>Grades 7-12</u> One (1) dose of Tdap vaccine must be administered prior to entry. **</p>
POLIO	<p><u>K-9</u> Three (3) or more doses of IPV. The FINAL dose must be administered on or after the 4th birthday regardless of the number of previous doses. If a combination of OPV and IPV was received, four (4) doses of either vaccine are required. ***</p> <p><u>Grades 10-12</u> Three (3) or more doses of IPV or OPV. If the third dose of either series was received prior to the fourth birthday, a fourth (4) dose is required; If a combination of OPV and IPV was received, four (4) doses of either vaccine are required.</p>
MMR Measles, Mumps, Rubella	<p><u>K-12</u> Two (2) doses of MMR. Dose one (1) must be administered on or after the first birthday. The second dose must be administered at least 28 days after dose one (1).</p>
HEP B Hepatitis B	<p><u>K-12</u> Three (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.</p>
Varicella (Chickenpox)	<p><u>K-9</u> Two (2) doses of varicella vaccine must be administered prior to entry. Dose one (1) must be administered on or after the first birthday. The second dose should be administered at least three (3) months after dose one (1); however, if the second dose is administered at least 28 days after the first dose, it is considered valid.</p> <p><u>Grades 10-12</u> One (1) dose of varicella vaccine must be administered on or after the first birthday.</p>
MCV4 Meningococcal	<p><u>Grades 7-10</u> One (1) dose of meningococcal (serogroup A, C, W, and Y) vaccine must be administered prior to entry.</p> <p><u>Grade 12</u> Two (2) doses of meningococcal (serogroup A, C, W, and Y) vaccine must be administered prior to entry. ****</p>

NOTES:

- Vaccine should be administered according to the most recent version of the *Recommended Immunization Schedule for Children and Adolescents Aged 18 Years or Younger* or the *Catch-up Immunization Schedule for Persons Aged 4 Months Through 18 Years Who Start Late or Who Are More Than 1 Month Behind*, as published by the Advisory Committee on Immunization Practices. Schedules are available for print or download at <https://www.cdc.gov/vaccines/schedules/index.html>.
- Vaccine doses 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 additional information please refer to the Ohio Revised Code 3313.67 and 3313.671 for School Attendance and the ODH Director's Journal Entry (available at <https://odh.ohio.gov/wps/portal/gov/odh/know-our-programs/Immunization/Required-Vaccines-Child-Care-School/>).

These documents list required and recommended immunizations and indicate exemptions to immunizations.

- Please contact the Ohio Department of Health Immunization Program at (800) 282-0546 or (614) 466-4643 with questions or concerns.

* 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 4th birthday, a sixth dose is recommended but not required.

** Pupils who received one dose of Tdap as part of the initial series are not required to receive another dose. Tdap can be given regardless of the interval since the last Tetanus or diphtheria-toxoid containing vaccine. DTaP given to patients age 7 or older can be counted as valid for the one-time Tdap dose.

*** 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.

**** Recommended MCV4 minimum interval of at least eight (8) weeks between dose one (1) and dose two (2). If the first (1st) dose of MCV4 was administered on or after the 16th birthday, a second (2nd) dose is not required. If a pupil is in 12th grade and is 15 years of age or younger, only 1 dose is required. Currently there are no school entry requirements for meningococcal B vaccine.

Ohio Department of Health • School and Adolescent Health

Physical Examination

Student's name		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth / /
Height	Weight	BMI percentile	BP

Screening Tests

Vision	Hearing	Postural
Date performed / /	Date performed / /	Date performed / /
Distance Acuity <input type="checkbox"/> R <input type="checkbox"/> L Muscle Balance <input type="checkbox"/> Pass <input type="checkbox"/> Fail Stereopsis <input type="checkbox"/> Pass <input type="checkbox"/> Fail Color <input type="checkbox"/> Pass <input type="checkbox"/> Fail Child wears glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No Tested with glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No Referral made? <input type="checkbox"/> Yes <input type="checkbox"/> No	Pure Tone Right ear <input type="checkbox"/> Pass <input type="checkbox"/> Fail Left ear <input type="checkbox"/> Pass <input type="checkbox"/> Fail Child wears hearing aid? <input type="checkbox"/> Yes <input type="checkbox"/> No Child under the care of a hearing specialist <input type="checkbox"/> Yes <input type="checkbox"/> No Referral made? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> No abnormality noted <input type="checkbox"/> Screening not done <input type="checkbox"/> Referral made Comments _____ _____ _____

Speech/Language

Speech assessment completed Yes No

Child has no discernible speech problem Yes No

Speech evaluation recommended Yes No

Child has possible problem with _____

Lead Poisoning

Date _____ Type C V Results _____ µg/dL

Date _____ Type C V Results _____ µg/dL

Tuberculin Test

Date _____ Type _____ Results _____

Health History (Serious or chronic illnesses/injuries/surgeries)

Physical Examination Date of most recent examination / /

Essentially normal Abnormalities as follows

Is this child able to participate fully in:

Classroom and academic activities	<input type="checkbox"/> Yes <input type="checkbox"/> No	Physical education classes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Competition athletics	<input type="checkbox"/> Yes <input type="checkbox"/> No	Contact and collision sports	<input type="checkbox"/> Yes <input type="checkbox"/> No

If limitations are advised, please specify

Does this child have any physical, developmental or behavioral issues that may affect his/her educational process?

HealthCare Provider's signature	Print name	Phone ()
Address		Date / /
City	State	ZIP



Ohio Department of Health School and Adolescent Health Immunization Report

Student's Name	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth / /
----------------	--	----------------------

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. Please note the month, day and year for each immunization should be on record.

Vaccine	Record complete dates (month, day, year) of vaccine doses given
Diphtheria, Tetanus, Pertussis (DTap,DT, Tdap, Td)	
Polio	
Hepatitis B (HBV)	
Measles, Mumps, Rubella (MMR)	
Varicella (Chicken pox)	
Hepatitis A	
Meningococcal (MCV4)	
Pneumococcal (PCV)	
Measles (Rubeola) only	
Rubella only	
Mumps only	
Haemophilus influenza Type b (Hib)	
Influenza	
Other	

This information was provided by Health Care Provider Parent/Guardian Other _____

Signature	Print Name	Date / /
-----------	------------	-------------