



# KENSTON

S C H O O L S

**Richard D. Timmons**  
Elementary School

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**David A. Rogaliner**  
Principal

**Kristen Hasenohrl**  
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February 25, 2019

Dear Parents/Guardians,

As you prepare for your child to begin Kindergarten, there are two medical forms which will need to be completed and returned in May, during screening.

- 1) School Entrance Medical Record: This form should be completed and signed by the parent/guardian. On this form, you will be able to communicate any health conditions/concerns, allergies and medications.
- 2) Kindergarten School Entrance Physical Examination & Immunizations: This form should be completed and *signed by your child's physician*. The physical must have been done within the last year (between August 15, 2018 and August 15, 2019). Your pediatrician will ensure that immunization records are current and provide dates of the immunizations, which are requirements for your child to attend school.

Please remember that these must be returned by Kindergarten screening in May.

Sincerely,

Mary Monroe, R.N.  
Timmons Health Aide

Melissa Kraus, R.N.  
Timmons Health Aide



Dear Parents:

Pupils enrolled in Preschool through Grade 12 are required to have on file, at their school, written proof that they have received the following immunizations which are required under Ohio Law Sections 3313.671 and 3701.13 of the Ohio Revised Code.

Preschool

DPT (Diphtheria, Pertussis, Tetanus) – Four (4) doses  
Polio (Poliomyelitis) – Three (3) doses  
MMR (Mumps, Measles, Rubella) – One (1) dose  
Hepatitis B – Three (3) doses  
Varicella (Chickenpox) – One (1) dose  
Hepatitis A – Two (2) doses  
HIB (Haemophilus influenza, type B) - Four (4) doses  
Influenza - Four (4) doses  
Pneumococcal - Four (4) doses  
Rotavirus – Three (3) doses

Kindergarten

DPT/DtaP (Diphtheria, Pertussis, Tetanus) – Four (4) or Five (5) doses  
Polio (Poliomyelitis) – Three (3) or Four (4) doses  
MMR – Two (2) doses  
Hepatitis B – Three (3) doses  
Varicella (Chickenpox) – Two (2) doses

Grades 1 – 12

DPT/DtaP (Diphtheria, Pertussis, Tetanus) – Three (3) or Four (4) doses  
Polio (Poliomyelitis) – Three (3) or Four (4) doses  
MMR – Two (2) doses  
Hepatitis B – Three (3) doses  
Varicella (Chickenpox) – Two (2) doses

Grade 7

DPT/DtaP (Diphtheria, Pertussis, Tetanus) – One (1) dose  
MCV4 (Meningococcal) – One (1) dose

Grade 12

MCV4 (Meningococcal) – Two (2) dose

According to Sections 3313.671 and 3701.13 and of the Ohio Revised Code on the 15<sup>th</sup> day after school entrance it will be necessary to exclude from school all pupils who have not been adequately immunized.

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

Please complete the attached School Entrance Medical Record and Immunization Information Form.

Revised: 1/2019



## PRESCHOOL/KINDERGARTEN SCHOOL ENTRANCE PHYSICAL EXAMINATION

(to be completed and signed by a physician)

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
(Month/Day/Year)

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_

General appearance, nutritional state: \_\_\_\_\_

	Normal	Abnormal		Normal	Abnormal	
Posture			Neck			Vision R 20/_____ L 20/_____
Skin			Heart			
Eyes			Lungs			
Ears			Abdomen			
Nose			Genitalia			Hearing Test Type: _____ R _____ L _____
Throat (Tonsils)			Hernia			
Mouth (Teeth)			Nervous System			
Musculoskeletal			Other (Specify)			

Remarks and recommendations concerning any abnormal findings:

\_\_\_\_\_

What medication, if any, is the child taking?

\_\_\_\_\_

Reason for medication: \_\_\_\_\_

Was child referred to a specialist for any reason (specify)? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Attach a copy of the child's current immunization record.**

Immunizations (circle one) Complete or In Process

### Special Tests (at discretion of physician)

Urinalysis: \_\_\_\_\_ Hemoglobin: \_\_\_\_\_ Other: \_\_\_\_\_

Other (specify type and dates): \_\_\_\_\_

Tuberculin Test: \_\_\_\_\_ Type: \_\_\_\_\_ Results: \_\_\_\_\_ Positive \_\_\_\_\_ Negative \_\_\_\_\_

Signature of Physician: \_\_\_\_\_ Date: \_\_\_\_\_

Physician (please print): \_\_\_\_\_ Phone Number: \_\_\_\_\_



**KENSTON**  
S C H O O L S

**PRESCHOOL ONLY**  
**SCHOOL ENTRANCE MEDICAL RECORD**  
**AND IMMUNIZATION INFORMATION**

(to be completed and signed by parent/guardian)

NAME: \_\_\_\_\_ BIRTHDAY: \_\_\_\_\_  
Month/Day/Year  
NAME OF PHYSICIAN: \_\_\_\_\_ TELEPHONE: \_\_\_\_\_  
NAME OF DENTIST: \_\_\_\_\_ TELEPHONE: \_\_\_\_\_

<b>DISEASE AND ILLNESS HISTORY (Give Year)</b>			
Chicken Pox:	Scarlet Fever:	Eczema:	Diabetes:
Measles:	Convulsions:	Ear Infections:	Heart Disease:
Mumps:	Strep Infection:	Hearing Problems:	Kidney Disease:
Rubella:	Hay Fever:	Vision Problems:	Other:
Any known physical handicaps (explain):			
Allergies or asthma (explain):			
Emergency treatment required (explain):			
Bee Sting Allergy/Food Allergy:			
Emergency treatment required (explain):			
Hospitalization (reasons and dates):			
Injuries or Operations (types and dates):			
Serious Illness (types and dates):			
Is your child currently on any medication?			
Name of medication:		Reason for medication:	
Will your child need this medication at school? (circle one)      Yes      No			
Other health problems (explain):			

**Family History**

Serious illness in immediate family (indicate family member)

Diabetes:	Tuberculosis:	Heart Disease:	High Blood Pressure:
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**Attach a copy of the child's current immunization record.**

Other (Specify type and dates): \_\_\_\_\_

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_