ST. DOMINIC SCHOOL

371 Pedretti Road
Cincinnati, OH 45238-5846
Telephone: (513) 251-1276 Fax: (513) 251-6428
www.stdominicdelhi.org

A Blue Ribbon School of Excellence

April, 2016

IMPORTANT PRESCHOOL REGISTRATION INFORMATION

Parents of students entering Preschool are required by the State of Ohio to provide information so the school can compile a complete health record for each child. We ask that the **attached form (both sides) be completed and returned to school by August 1, 2016.**

Ohio law mandates that preschool children have certain immunizations (shots), a yearly physical and a Preschool Medical Statement on file for school attendance.

The yearly physical form expires one year from the date the exam was completed. You will be asked to have a new physical form completed if the exam expires within the school year.

All students must show proof of meeting the minimum state immunization requirements before entering school. All students in Preschool must have:

1. 4 doses of Dtap, DTP, or DT or any combination, if the fourth dose was administered prior to the 4th birthday.
2. 3 doses of all OPV or all IPV is required if the third dose of either vaccine was administered prior to the 4th birthday.
3. 3 doses of Hepatitis B.
4. 1 dose of MMR. Dose 1 must be administered on or after the first birthday. The second dose must be administered at least 28 days after dose 1.
5. 1 dose of Varicella vaccine must be administered on or after the first birthday.
6. 4 doses of Hib as an infant or 1 dose if given after the first birthday.

When completed, the form can either be dropped off or mailed to the school office. If you have any questions, you may call the office at 251-1276 ext. 430 to speak with Mrs. Jenny Schwarz, our school nurse.

We thank you for your cooperation in returning the information in a timely manner.

Sincerely,

William S. Cavanaugh

William S. Cavanaugh
Principal

St. Dominic School Preschool Medical Statement

Please note: Preschool students must have a yearly examination shortly after their birthday.

Child's Name_____ Date of Birth_____

Height_____ Weight_____ BMI_____

Mother/Guardian's Name_____ Phone:_____

Father/Guardian's Name_____ Phone:_____

Immunizations	Please Circle One	
Complete for Age	Yes	No
In Process	Yes	No
Comments:		

Exempt from Immunizations	Please Circle One	
Religious Conviction	Yes	No
Health Concern	Yes	No
Other:		
Signature:		

Required for children enrolled in an Early Childhood Education Grant Program or Preschool Special Education Program				Reason Not Completed (check which applies)	
Assessments/Screenings	Completed Please Circle One		Date Completed	Health Professional Decision	Examples: Religious Conviction, Insurance Coverage, Other
Vision	Yes	No			
Hearing	Yes	No			
Dental	Yes	No			
Lead	Yes	No			
Hemoglobin	Yes	No			

Chronic Physical Problems:
Developmental or Behavioral Problems:
Speech Problems:
Dietary Restrictions:
Allergies & Treatments:
History of Hospitalizations:
Diseases Child Has Had:
Medications, Food Supplements, Modified Diet or Fluoride Supplements:

This child has been examined and is in suitable condition to participate in group care.

Signature of Physician / Physicians Assistant / Advanced Practice Nurse (circle one)

_____ Date of Exam_____

Address: Phone:

IMPORTANT: Please attach a copy of your child's immunization records.

Return form and immunization records to the school office by August 1, 2016.

Parent/Guardian Signature _____