ST. DOMINIC SCHOOL

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A Blue Ribbon School of Excellence

April 2018

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, 2018.**

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.

Please attach the child's list of immunizations to the enclosed forms.

When completed, the forms 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

Ohio | Department of Education

Office of Early Learning and School Readiness

Child Medical Statement

Revised 7/11/2016

This form meets Ohio Administrative Code. Programs may use this form or build their own.

Section I - Child Medical Information

Child's Name _____

Date of Birth _____ Height _____ Weight _____

Immunizations:		**Exempt from Immunization:**	
Complete for Age	○ Yes ○ No	Religious Conviction	○ Yes ○ No
In Process	○ Yes ○ No	Health	○ Yes ○ No
		Other	

Limitations or health conditions, including allergies, medications, and dietary restrictions.

Section II - Child Medical Statement Verification

Physician/Clinic/Hospital Name _____ Provider Address _____

Provider Phone Number _____ Provider City _____ Provider State _____ Provider Zip _____

Check box of examining medical professional:

- ☐ Physician
- ☐ Physician's Assistant
- ☐ Advanced Practice Nurse

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

Signature of Medical Professional _____ Date of Exam _____

Programs funded through the Ohio Department of Education must have written policies and procedures to ensure that children have received comprehensive health screenings and/or that families are informed of the importance of health screenings and the resources to obtain them.

Ohio | Department of Education

Office of Early Learning and School Readiness

Preschool Registration Form

Revised 3/14/2017

This form meets Ohio Administrative Code. Programs may use this form or build their own.

Section I - Student & Family Information

Child's Name _____ Date of Birth _____

Family/Guardian Name _____

Please select 1, 2 or 3 to set call order of phone number used to reach you:

Home Address _____ Cell Phone _____ Call Order _____

City _____ State _____ Zip _____ Home Phone _____ Call Order _____

Employer Name _____ Work Phone _____ Call Order _____

Employer Street Address _____ City _____ State _____ Zip _____

Alternate Family Information:

Please select 1, 2 or 3 to set call order of phone number used to reach you:

Family/Guardian Name _____ Cell Phone _____ Call Order _____

Family Street Address _____ Home Phone _____ Call Order _____

City _____ State _____ Zip _____ Work Phone _____ Call Order _____

Employer Name _____

Employer Street Address _____ City _____ State _____ Zip _____

Section II - Authorization for Emergencies

List 2 Emergency Contacts for use ONLY if the parents cannot be contacted:

Name _____ Name _____

Street Address _____ Street Address _____

City _____ State _____ Zip _____ City _____ State _____ Zip _____

Please select 1, 2 or 3 to set call order of phone number used to reach emergency contact:

Home _____ Call Order _____ Home _____ Call Order _____

Cell _____ Call Order _____ Cell _____ Call Order _____

Work _____ Call Order _____ Work _____ Call Order _____

List Medical Contacts, In Case Of Emergency:

Physician _____ Dentist _____

Street Address _____ Street Address _____

City _____ State _____ Zip _____ City _____ State _____ Zip _____

Phone _____ Phone _____

Section III - Child's Health Information

Child's Chronic Medical/Health Needs

Please complete both pages of form

Child's History of Hospitalization:

Child's Disease History:

Child's Allergies/Treatment:

Child's Dietary Needs/Restrictions:

NOTE: A MEDICATION FORM MUST BE COMPLETED FOR EACH MEDICATION ADMINISTERED WHILE IN PROGRAM ATTENDANCE

Child's Medication/s:

Section V - Registration Authorizations

I authorize the following to be listed on the parent roster:
- My child's name ☐ Yes ☐ No
- Family name ☐ Yes ☐ No
- Phone numbers ☐ Yes ☐ No ☐ Cell ☐ Home ☐ Work

Annual Class Roster: Each year the program prepares a roster for each group of children. This roster will not be furnished to any persons other than parents of children enrolled in our program.

Exempt from immunizations because of religious conviction: ☐ Yes ☐ No

Child immunization records attached: ☐ Yes ☐ No

Date

Signature of Authorized Family Member/Guardian