NORWOOD CITY SCHOOL DISTRICT 2019-20

Kathy Strasser, District Nurse

Dear Parent/Guardian of Norwood students,

Compulsory immunization requirements for school attendance (Pre-School through 12th grade) are determined by the state of Ohio as set forth in the Ohio Revised Code. Students must have documentation of sufficient immunizations upon registration.

Required immunizations 2019-20 school year are as follows:

- All K-12th grade students must have received the Hepatitis B Vaccine series. A minimum of three doses is required.
- All K-12th grade students must have received two doses of MMR (measles, mumps, and rubella).
- All Kindergarten students must have a minimum of 5 DTaPs. Grades 7-11 must have had one additional dose of Tdap vaccine administered prior to entry into school.
- All Kindergarten students must have had a 4th polio vaccine if they received a combination of OPV and IPV. Students who received all OPV or all IPV and received the third dose on or after the fourth birthday, are not required to have the 4th vaccine.
- All students (PK-12th) that are from, or have traveled to, a high risk country for Tuberculosis, MUST have a tuberculosis (TB) skin test upon registration.
- All K-7th grade students must have had 2 doses of the varicella vaccine; grades 8th-11th must have one dose administered after the first birthday.

Immunization clinics are routinely held on the 2nd and 4th Monday afternoon of each month, 2-4pm, at the Norwood Health Department. Other times and dates are available upon request. Costs are minimal. CareSource is accepted as payment for immunizations.

Birth certificates are required for school enrollment. Ohio birth certificates are available at the Norwood Health Department for $25. For additional information concerning immunizations/birth certificates, please call the Norwood Health Department at 458-4600.

Thank you for your consideration on this important health issue.

Respectfully,

Kathy Strasser, RN

District School Nurse

NORWOOD CITY SCHOOL DISTRICT 2019-20

Ohio School History
Historia de Escuela de Ohio

School: _____
Escuela

Physician Assessment
Evaluación de Médico

Enrolled: _____
Matriculada

Name(Firma):_____ Gender: _____ Age:_____ DOB: _____

Ethnicity: ☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian American ☐ Other

Objective Data:

Height_____ Weight: _____ B.P.:_____

IMMUNIZATION
Required for school entry

TYPE	DATE: MO/DAY/YEAR					
DtaP, DPT or DT						5th dose required if 4th dose given before 4th b-day for **Kindergarten**
DT/Td					**Grades 1-12:** 4 doses of DtaP, DTP, DT or Td or any combination **Grade 7-12: 1 dose of Tdap or Td prior to entry**	
POLIO					**K-8** students must have 3 or 4 doses of IPV, final dose on or after 4th birthday; 4 doses if a combination of OPV/IPV. **Grades 9-12** 4 doses if combination IPV/OPV. 4 doses if all IPV/OPV & if the final dose was given before 4th birthday	
MMR					**KG-12**: 2 doses required for 2019-20	
HEPATITIS B					**KG-12**: 3 doses required for 2019-20	
VARICELLA					**K-8** must have 2 doses for 2019-20 **Gr. 9-12** must have 1 dose for 2019-20	
HIB (prior to age 5 only)					0-14 months; 3-4 doses, 5-59 months; 1 dose	
TUBERCULIN TEST					**Required if traveled to high-risk area**	
ROTAVIRUS (given @ 2-4-6 mo. Not after 12 mos.)						
OTHER						

SCREENING TESTS

Vision: Date:	Hearing: Date:
Distance Acuity Right_____ Left_____ Muscle Balance ☐ Pass ☐ Fail ☐ Not Done Farsightedness ☐ Pass ☐ Fail ☐ Not Done Color ☐ Pass ☐ Fail ☐ Not Done Child Wears Glasses? ☐ Yes ☐ No Tested With Glasses? ☐ Yes ☐ No Referral Made? ☐ Yes ☐ No Specify Test/Equipment:_____	Pure Tone Testing: Right Ear ☐ Pass ☐ Fail ☐ Not Done Left Ear ☐ Pass ☐ Fail ☐ Not Done Child Wears Hearing Aid? ☐ Yes ☐ No Testing With Hearing Aid? ☐ Yes ☐ No Referral Made? ☐ Yes ☐ No Other Test(specify):_____

SPEECH ASSESSMENT Date:

☐ Child has no discernible speech problem
☐ Child has possible problem with: ☐ Articulation ☐ Rhythm ☐ Voice ☐ Language

Speech evaluation is recommended: ☐ Yes ☐ No

LABORATORY TESTS

**ODH Lead Testing Requirement: ages 6-72 months

☐ Hemoglobin/Hematocrit ☐ Urine Protein ☐ Urine Blood ☐ Urine Glucose
☐ **BLL (Blood Lead Level):_____

PHYSICAL EXAMINATION

**Kindergarten students must have a signed physician exam on file with the school within 30 days of admission. The exam must have been given within the year.

Date of Examination: _____

- ☐ This child is essentially within normal limits
- ☐ This child is not within normal limits

Explain:

Does this child have any physical, developmental or behavioral problems? Suggest special programs, placement or attention that the school can provide.

ACTIVITIES & LIMITATIONS

Can the child participate fully in the following activities?

Classroom and academic activities	☐ Yes ☐ No
Physical Education classes	☐ Yes ☐ No
Competitive Athletics	☐ Yes ☐ No
Contact & Collision Sports	☐ Yes ☐ No

Specify any limitations:

Is this child on any medications? ☐ Yes ☐ No

Explain:

Examiner's Signature: _____ Date signed: _____

Examiner's Printed Name: _____

Address: _____

Phone: _____

NORWOOD CITY SCHOOL DISTRICT 2019-20

Ohio School History
Historia de Escuela de Ohio

Dentist Assessment
Evaluación de Dentista

School: _____
Escuela

Enrolled: _____
Matriculada

ORAL ASSESSMENT

Child's Name:_____ Gender: ☐ M or ☐ F Age:____ DOB:_____

Ethnicity:
☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian American ☐ Other

The following services have been performed:

☐ Examination by Dentist ☐ Orthodontic Assessment ☐ Oral Screening
☐ Dental Sealants ☐ Radiographs ☐ Fluoride Application
☐ Oral Prophylaxis (cleaning) ☐ Diagnosis ☐ Rx for fluoride supplements

The following oral hygiene instruction was provided:

☐ Brushing teeth ☐ Diet counseling related to dental health
☐ Flossing ☐ Home/school use of fluoride mouth rinse

The following statements are applicable:

☐ No apparent care needed at this time.
☐ All necessary preventative services have been performed. (Fluoride treatment, prophylaxis)
☐ No restorative services are required at this time.
☐ Further treatment is indicated. (See comments)
☐ Further appointments have been arranged. (ex. Orthodontic, restorative)

Comments:

Examiner's Signature: _____ Date signed: _____

Examiner's Printed Name: _____
Address: _____
Phone: _____

NORWOOD CITY SCHOOL DISTRICT 2019-20

ADMINISTRATION OF MEDICATION AT SCHOOL

School policy requires consent of the parent/legal guardian and written statement from the licensed prescriber before school personnel can give any **prescribed or over-the-counter** medication to a student. Please complete this form and return to the school office.

NAME OF STUDENT: _____DOB:_____/_____/_____ GRADE: _____ HR: _____

ADDRESS: _____PHONE#:_____

ALLERGIES: _____

To be completed by LICENSED PRESCRIBER

In accordance with the ORC 3313.713/3313.716 The Licensed Prescriber MUST provide the following information before a students is allowed to receive medication at school or possess and self-administer and asthma inhaler.

Condition for which medication is administered: _____

Name of medication, dose and route: _____

Time or indication for administration: _____

Specific instructions for administration: _____

Possible side effects to be noted/reported: _____

Effective Date: _____/_____/_____ **Expiration date of this request: _____/_____/_____**

FOR ASTHMA INHALERS, EPI-PENS, INSULIN PUMPS – In my opinion, this student shows the ability to administer and be responsible for carrying and self-administering the above medication. **YES**_____ (initials) **NO**_____ (initials)

The following section is REQUIRED for ASTHMA INHALERS that a student is carrying and self-administering, and is OPTIONAL for other medications.

Instructions to follow in the event medication does not produce expected relief:

_____

_____

Licensed Prescriber Signature_____ Printed Name _____

Date_____ Phone Number_____

To be completed by PARENT/GUARDIAN

I give permission for the principal or his/her designee to administer the medication as prescribed above to my child, and further agree to the following:

1. Submit to school personnel a revised statement, signed by the licensed prescriber of the above, when any change in the original statement occurs.
2. Submit to school personnel a written statement when medication has been discontinued.
3. Grant permission for the school nurse to confer with the above licensed prescriber regarding my child's health and treatment issues as they pertain to the above medication/diagnosis and his/her educational and behavioral management needs.
4. Cooperate with school personnel in assisting my child comply with medication administration instructions.
5. All Medications must come to school in the **original container** from the pharmacist.

For INHALERS, EPI-PENS, AND INSULIN PUMPS: It is my opinion that my child understands the use of this medication, demonstrates proper administration, and has shown responsible behavior when it comes to carrying this medication. I further understand that my child will sign a contract stating he/she will be responsible for the medication during school. **YES**_____ **NO**_____ INITIALS_____

_____ _____/_____/_____ _____

Parent/Guardian Signature Date Daytime Phone Number

****THIS FORM EXPIRES AT THE END OF THE 2019-20 SCHOOL YEAR****

Section 504 of the ADA Amendments Act of 2008 ADAAA

Section 504 of the Rehabilitation Act of 1973 requires a public school district to identify each child who has a disability that substantially limits a major life function such as learning, eating, sleeping, etc. If you believe your child's health condition substantially limits a major life function, he/she may qualify for an evaluation to determine Section 504 eligibility. Please feel free to contact the Norwood City Schools' Special Education Coordinator, Joe Miller, at 924-2502 or Norwood City Schools' district nurse, Kathy Strasser at 924-2882.