



**SAINT CHARLES PREPARATORY SCHOOL
STATE OF OHIO IMMUNIZATION REQUIREMENTS**

Dear St. Charles Parents:

The State of Ohio and St. Charles Preparatory School require specific immunizations and tests for new students entering the school. The purpose of this requirement is to protect the health of the student body as well as the individual.

Attached to this letter are the immunization requirements listed by the Ohio Department of Health for all students enrolled in the state.

A physical examination is required for admission to St. Charles. The form for this accompanies this letter or you may use the form provided by the Ohio High School Athletic Association at <http://www.ohsaa.org/medicine/physicalform.htm>. Please have this completed before the first day of school.

The physical form and immunization record are required before a student receives his schedule. **Classes may not be attended until this requirement is met.**

We must strictly enforce this policy because of state requirements, and we are confident about your cooperation.

Should you have any questions about these issues, please feel free to contact me (614-252-6714 ext. 15 or midgecull@hotmail.com) at your convenience.

Sincerely,

Midge Cull

St. Charles School Nurse

MEDICAL HISTORY

Name (Print) _____ Date of Birth _____
Last Name First Name Middle Name

Address _____
Street City State Zip Code

Home Phone Number _____

Mother's Name _____ Father's Name _____

Mother's Address _____ Father's Address _____

Mother's Home Phone _____ Father's Home Phone _____

Mother's Work # _____ Father's Work # _____
Car Pager Cell Car Pager Cell

IMMUNIZATIONS:

DPT #1 _____ ORAL POLIO #1 _____ RUBEOLA (10 day measles) _____

DPT #2 _____ ORAL POLIO #2 _____ RUBELLA (3 day measles) _____

DPT #3 _____ ORAL POLIO #3 _____ MUMPS (optional) _____

DPT #4 _____ ORAL POLIO #4 _____ MMR #1 _____ MMR #2 _____

DT BOOSTER _____ TB SKIN TEST _____ RESULT _____ HEP B #1 _____ #2 _____ #3 _____

Family History

Among your blood relatives, is there any history of, or present illness of any of the following:

Check: Yes / No:	Relationship:	Yes / No:	Relationship:
Cancer _____	_____	Tuberculosis _____	_____
Heart Disease _____	_____	Diabetes _____	_____
High BP _____	_____	Nervous/Mental Disease _____	_____
Stroke _____	_____	Asthma or Hay Fever _____	_____
		Convulsions _____	_____

Are your parents living? _____ Number of brothers living _____ Number of sisters living _____

If deceased, give relationship and cause of death _____

Have you ever had or do you now have any of the following:

Check: YES/NO

Allergies: food, drugs, other _____	Epilepsy _____	Mononucleosis _____	Scarlet Fever _____
Anemia _____	Hay Fever _____	Mumps _____	Sinus Disease _____
Appendicitis _____	Heart Disease _____	Nervous/Mental Disease _____	Skin Disease _____
Arthritis _____	Hepatitis _____	Pneumonia _____	Thyroid Trouble _____
Asthma _____	Kidney Disease _____	Rheumatic Fever _____	Tonsilitis _____
Diabetes _____	Measles (7-10 day) _____	Rubella (3 day measles) _____	Tuberculosis _____
Ear Disease, mastoid, etc. _____	Meningitis _____	Rupture or Hernia _____	Ulcer _____
			Vertigo (Dizziness) or Fainting Spells _____

If YES, or any other diseases, give details: _____

Check: YES / NO **If yes, please explain:**

1. Have you ever been unable to take physical education or participate in sports because of your health? _____
2. Current medical problems _____
3. Have you consulted, been treated or been counseled by a physician or clinic in the past five years? _____
4. Have you ever had any serious illness, injury, or operation not listed above? _____
5. Have you had a chest X-ray? If yes, give date and results _____

PHYSICAL EXAMINATION

TO THE PHYSICIAN: Please correlate the student's medical history with your findings and record below.

Name _____

(Last Name)

(First)

(Middle)

(Birthdate)

1. **Sex** _____ 2. **Age** _____ 3. **Build:** Slender _____ Medium _____ Heavy _____ Obese _____

4. **Height** _____ 5. **Weight** _____ 6. **Blood Pressure** S _____ / D _____ 7. **Pulse** _____

8. **Urinalysis:** Albumin _____ Sugar _____ 9. **Hearing:** Right _____ Left _____

10. **Vision:** Right 20/ _____ Left 20/ _____

Color Vision: _____ Test Used: _____

Corrected to: Right 20/ _____ Left 20/ _____

Check Each Item In Proper Column	Normal	Abnormal	Note: Give details of each abnormality. Enter corresponding item number before each comment.
11. Head, neck, face and scalp			
12. Nose and Sinuses			
13. Mouth, Teeth, Gingiva and Throat			
14. Ears – General (Canals, Drums, etc.)			
15. Eyes – General (Lids, Pupils, Motions)			
16. Lungs, Chest, and Breasts			
17. Heart			
18. Vascular System (Include Varicosities)			
19. Abdomen and Viscera (Include Hernia)			
20. Ano-Rectal and Pilonidal)			
21. Endocrine System			
22. Genito-Urinary System			
23. Upper Extremities			
24. Lower Extremities (Include Feet)			
25. Spine, Other Musculo-Skeletal			
26. Skin and Lymphatics			
27. Neurological System			
28. Psychiatric (Personality Deviation, etc.)			
29. Other			

30. ANY SPECIAL TESTS USED FOR YOUR CLINICAL EVALUATION? (BLOOD, EKG, etc.) _____

All students (except those entering with sophomore standing) are required to enroll in the physical education program.

Please check either "A" or "B":

_____ A. This student **can participate** in a program of physical education which includes such sports as basketball, baseball, soccer, tennis, swimming, volleyball, and "tag" football.

_____ B. This student should be enrolled in a **restricted program** of physical education. I make this recommendation for this reason:

Physician's Name: _____

Physician's Signature: _____

Physician's Phone Number: _____

Date of Exam: _____

Street Address: _____

City/ State/ Zip _____

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*******NOTE: PLEASE COMPLETE IMMUNIZATION DATA ON REVERSE SIDE ! THANK YOU**

Immunization Summary for Child Care, Head Start, Pre-School and School Attendance

VACCINES	<i>FALL 2010</i> IMMUNIZATIONS FOR CHILD CARE/HEAD START AND PRE-SCHOOL ATTENDANCE	<i>FALL 2010</i> IMMUNIZATIONS FOR SCHOOL ATTENDANCE
DTaP/DTP/DT Tdap/Td Diphtheria, Tetanus, Pertussis	4 doses of DTaP, DTP, or DT or any combination.	Kindergarten 5 doses of DTaP, DTP, or DT, or any combination, if the fourth dose was administered prior to the 4 th birthday Grades 1-12 3-4 doses of DTaP, DTP, DT or Td or any combination. Grade 7 1 dose of Tdap or Td vaccine must be administered prior to entry.
POLIO	3 doses of OPV or IPV or any combination of OPV or IPV.	Kindergarten 4 doses of any combination of OPV or IPV, the final dose must be administered on or after the 4 th birthday regardless of the number of previous doses. Grades 1-12 ** 4 doses if a combination of OPV or IPV was administered. 4 doses of all OPV or all IPV is required if the third dose of either vaccine was administered prior to the 4 th birthday.
MMR Measles, Mumps, Rubella	1 dose of MMR administered on or after the first birthday	K-12 2 doses 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.
Hib <i>Haemophilus Influenzae</i> Type b	3 or 4 doses depending on the vaccine type, the age when the child began the 1 st dose and the last dose must be after 12 months or 1 dose if given on or after 15 months of age	None
HEP B Hepatitis B	3 doses of Hepatitis B	K-11 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.
Varicella (Chickenpox)	None	Kindergarten 2 doses of varicella vaccine must be administered prior to entry. Grade 1-4 1 dose of varicella vaccine must be administered on or after the first birthday

****Students enrolled in school on or after the 1999-2000 school year should have received a total of four doses of polio vaccine. Students enrolled prior to the 1999-2000 year are required to have a minimum of 3 doses.**

NOTES:

- The 4 day “grace” period applies to all age and interval minimums. If MMR and Varicella have not been given on the same day they must be separated by at least 28 days with no grace period.
- The Hepatitis B, Tdap and Varicella requirements will be progressive.
- Only full doses of vaccine using proper intervals shall be counted as valid doses.
- For additional information please refer to the Ohio Administrative Code 5101:2-12-37 for Child Care, Head Start, Pre-School and the Ohio Revised Code 3313.67 and 3313.671 for School Attendance. 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.