



Student Health Record

DAYTON CHRISTIAN SCHOOL
 9391 Washington Church Road, Miamisburg, OH 45342
 Admissions Office: (937) 291-7218 FAX: (937) 291-7213
 Clinic: (937) 291-7252 FAX: (937) 291-7254
 www.DaytonChristian.com

Student Name:			Date:		
Birthdate:		Gender:	School:		Grade:
Parent(s)/Guardian:					
Home Address:			City:		Zip:
Home Phone:		Cell #:		Work #:	

PRE-SCHOOL - REQUIRED PHYSICAL EXAM					
<i>As the State requires yearly physicals, this exam is best done 6/15 through 8/15</i>					
Preschool Physical Exam Date:			Physician's Signature: ★		
Physician's Address:			City:		State: Zip:
Allergies:					

★ Or Certified Nurse Practitioner

REQUIRED IMMUNIZATIONS PRE-K THROUGH 12th GRADE										
NOTE TO PARENTS: Dayton Christian School System also requests a copy of the immunization record on either the physician's office form or the county health department form to accompany this health record. Day, month and year of each dose received is required.										
DATES						★K				DATES
DPT										MMR:
	1	2	3	4	*5	6				1 2 (K-12)
TD, Tdap										****Varicella
	**1									1 2
Polio										TB, Maintoux (International students ONLY)
	1	2	3	4	***5					1
Preschool HIB										Other
	1	2	3	4						
Hepatitis B										Other:
(Grades PreK -11)	1	2	3							

*Students receiving all four (4) primary immunization doses of DTP or DTaP prior to their 4th birthday MUST receive a single booster dose prior to kindergarten entry.

** One dose of Tdap or Td is required prior to entry into the 7th grade.

***Students receiving their 3rd or 4th dose prior to their fourth birthday – an additional dose is required.

**** Varicella: One dose K-6, 2 doses K-2

Weight:
Height:

RECOMMENDED ITEMS FOR GRADES K-12 PHYSICAL AND MANDATED PRESCHOOL PHYSICAL

The State requires physicals to be done yearly for preschool students. Pre-school exam best done 6/15 - 8/15.

Did examination reveal any abnormalities in the following areas?

	YES	NO		YES	NO		YES	NO
General Appearance			Neuro Muscular			Skeletal System		
Abdomen			Skin			Lymph Nodes		
Eyes			Ears			Noses/Throat		
Lungs			Genitalia			Teeth/Gums		
Tongue and Palate			Heart BP:			Emotional		

DESCRIBE FULLY ANY ABNORMALITIES:

HCT>34% is acceptable for 3--4 YR	HCT>36% is acceptable for 4--5 YR	HGB: 12% to 18% is acceptable for all ages
F.E.P., if HCT or HGB fall below amount indicated.		
Lead Test if R.E.P. is High:	Sickle Cell Anemia:	Urinalysis:
Hearing:	Speech:	Vision:

Please list any severe or life threatening injuries or illnesses:

	Age of Child	Hospitalized:	
		YES	NO

Indicate your child's past/present disease(s):

<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Epilepsy, Seizures	<input type="checkbox"/> Frequent Skin Infections	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Meningitis
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> German Measles	<input type="checkbox"/> Sickle Cell Disease	<input type="checkbox"/> Mumps
<input type="checkbox"/> Eczema	<input type="checkbox"/> Old Fashion Measles	<input type="checkbox"/> Encephalitis	<input type="checkbox"/> Hepatitis B
<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Asthma or Wheezing	<input type="checkbox"/> Other	<input type="checkbox"/> Stool Soiling

Is your child on any medication? Yes No Please indicate the medication and reason it is being taken:

Are there medications given "as needed" Yes No Please indicate reason medication is being taken:

Does student have a physical handicap? <input type="checkbox"/> Yes <input type="checkbox"/> No Explain:	Has student ever had a convulsion? <input type="checkbox"/> Yes <input type="checkbox"/> No Explain:
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Describe student's eating habits including modified diets; food supplements or fluoride supplements if any:

Does student have trouble with bladder control? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is student a bed-wetter? <input type="checkbox"/> Yes <input type="checkbox"/> No
Poor Vision? <input type="checkbox"/> Yes <input type="checkbox"/> No	Chronic diarrhea or constipation? <input type="checkbox"/> Yes <input type="checkbox"/> No
Poor Hearing? <input type="checkbox"/> Yes <input type="checkbox"/> No	Please state any health problems the school should know about:
Would you say student is <input type="checkbox"/> very active, <input type="checkbox"/> average, <input type="checkbox"/> quiet	
Nervous twitching or tics? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Physical Activity: Limitations? <input type="checkbox"/> Yes <input type="checkbox"/> No (If child has limitations, please send a note from your physician to the school.)	