EMERGENCY INFORMATION:

Date of Admission_____
Child's Name_____ Birth date _____

Full Address_____ City_____State_____Zip_____

Home Phone _____ Child's Religion_____

Father's Name_____ Mother's Name_____

Cell Phone #_____ Cell Phone #_____

Father's Email_____ Mother's Email _____

Father's Work_____ Mother's Work_____

Father's Business Address_____ Mother's Business Address_____
_____ _____

Business Phone #_____ Business Phone #_____

Doctor_____ Telephone #_____

Address_____ City_____State_____Zip_____

Dentist_____ Telephone #_____

Address_____ City_____State_____ Zip_____

If one of the child's parents does not live at the child's home address, please give address and telephone #:
_____

The State of Ohio requires three (3) emergency contacts in the event that a parent cannot be reached.
1) Name_____ Relationship to Child_____
Home Phone #_____ Work # _____ Cell # _____
2) Name_____ Relationship to Child_____
Home Phone #_____ Work # _____ Cell # _____
3) Name_____ Relationship to Child_____
Home Phone #_____ Work # _____ Cell # _____
Please list the name(s) of individuals your child may be released to:
_____

Health Record
List of Allergies: _____
List of Chronic Physical Problems:_____
List any diseases child has had:_____
History of Hospitalization_____
List any medications, food supplements, and modified diet or fluoride supplements currently being administered to child: _____
Immunization Record: Enter month/day/year
DPT: 1 _____ 2 _____ 3 _____ 4 _____ 5 _____
POLIO: 1 _____ 2 _____ 3 _____ 4 _____
HIB: 1 _____ 2 _____ 3 _____ 4 _____
MEASLES/ MUMPS/ RUBELLA (usually combined as MMR)
If separate, MEASLES_____ MUMPS_____ RUBELLA_____

TO GRANT CONSENT

Part I: PERMISSION TO GRANT CONSENT

I give Springs East School permission to transport my child, _____
1) To (Hospital or Clinic) _____ for emergency medical care.
2) To (Dentist or clinic) _____ for emergency dental care or to the nearest available source of assistance.
3) To and from Springs East School for reasons such as heat loss, field trips and other special events.
4) To or from the Public School, in the event your child misses their Kindergarten bus.

Part II: REFUSAL TO GRANT CONSENT

I do not give permission to Springs East to transport my child, _____ for emergency medical or dental care. In the event of an illness or injury which requires emergency medical or dental treatment, I wish the following action to be taken:

_____

_____

(supply information)

SIGNATURE OF PARENT _____

ROSTER PERMISSION

_____ I grant permission to have my child's name, address and phone number included in the school roster.

_____ I do not want my child's name, address and phone number included in the school roster.

SIGNATURE OF PARENT _____

VERIFY THAT YOU HAVE READ DISCIPLINE POLICY

_____ I have read the "discipline policy" located in the Handbook.

SIGNATURE OF PARENT _____

****

Ohio | Department of Education

Office of Early Learning and School Readiness

Child Medical Statement

Revised 3/12/2018

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 Assistant
- ☐ Advanced Practice Registered 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.

CHILD'S MEDICAL STATEMENT

This is to certify that (child's name)_____
DOB _____was examined by me on (date)_____.

1) Has had the immunizations required by Section 3313.671 of the Revised Code for admission to school, or has had the immunizations required by the State Department of Health for pre-school and school age children, or is to be exempted from these requirements for medical reasons.

IMMUNIZATION RECORD: (Please enter month, day and year)

DPT 1_____2_____3_____4_____ 5_____

POLIO 1_____2_____3_____4_____

HIB 1_____ 2_____3_____ 4_____

HEPB 1_____2_____3_____

MEASLES, MUMPS, RUBELLA-usually combined as MMR_____
If separate: MEASLES_____MUMPS_____RUBELLA_____
*The 5th DPT and the 4th Polio are normally administered just prior to Kindergarten.

2) Based upon his/her medical history and physical condition at the time of this examination, is free from all apparent communicable disease and is in good health for enrollment in school (ages 3 yrs thru 9 yrs.)

Physician's Signature_____

Street Address_____

City, State, Zip_____

Telephone # _____

Return via: Fax (513) 271-1684, email: springseastschool@cinci.rr.com, or mail 9429 Loveland-Madeira Rd, Cincinnati OH 45242