



## Kindergarten Registration Letter

Dear Kindergarten Parents/Guardians:

It is with much anticipation that we await your child's entrance into Kindergarten! Nursing services in this school district are provided by Akron Children's Hospital School Health Services. Akron Children's Hospital School Health Services is dedicated to supporting the academic success of all children and youth through health promotion, education and child advocacy.

The following forms are needed for school entry:

1. **Emergency Medical Authorization**, REQUIRED AT REGISTRATION.
2. **School Health Record** provides a student health history, completed by parent, REQUIRED AT REGISTRATION.
3. Current **Immunization Record**, completed by the doctor, REQUIRED AT REGISTRATION. Please bring the record even if your child has not had the final boosters yet. We can make a copy if you have the original. State of Ohio health law requires the following immunizations for school entry:

DPT, DTaP	5 doses
Polio	4 doses
MMR	2 doses
Hepatitis B	3 doses
Varicella	2 doses or documented date of disease

Please note: Immunizations must be completed within 15 days of starting school, or your child may be excluded from attendance by the principal. Immunizations can be obtained through your child's primary

**In addition, if your child has a medical condition that may need intervention at school, for example asthma, food allergies, medications, etc., please call us so accommodations can be arranged.**

We are looking forward to healthy school year!

Sincerely,

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Akron Children's Hospital School Health staff

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Phone/Fax



School Health Record  
 (to be completed/signed by parent or guardian)  
 School Year: \_\_\_\_\_

Student Name: \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Date of birth: \_\_\_\_\_

**Immunizations: (Required by Ohio Law to attend school)**

Vaccine	1 <sup>st</sup> Dose	2 <sup>nd</sup> Dose	3 <sup>rd</sup> Dose	4 <sup>th</sup> Dose	5 <sup>th</sup> dose	Comments
DPT						<b>Kindergarten</b> 5 <sup>th</sup> dose required if 4 <sup>th</sup> dose before age 4 <b>Grades 1-12</b> 3-4 doses
Polio					N/A	4 <sup>th</sup> dose required on or after 4 <sup>th</sup> birthday
MMR			N/A	N/A	N/A	Two doses required for grades K-12
Hepatitis B				N/A	N/A	Three doses required for K-11 (Recommended for grade 12)
Varicella Chicken Pox		Kindergarten only	N/A	N/A	N/A	<b>Kindergarten</b> One dose on or after the 1 <sup>st</sup> birthday Second dose at least 28 days after 1 <sup>st</sup> dose. <b>Grades 1 – 4</b> One dose on or after the 1 <sup>st</sup> birthday
HIB						<b>Required for preschool</b> 0-14 months: 3-4 doses 15-59 months: 1 dose
Tdap or Td		N/A	N/A	N/A	N/A	Booster prior to entry into 7 <sup>th</sup> grade
TB Test	Negative	Positive				Not required for school entry
Other						

**Lead Poisoning (PRESCHOOL ONLY):**

Date \_\_\_\_\_ Results \_\_\_\_\_

**Hemoglobin/Hematocrit (PRESCHOOL ONLY):**

Date \_\_\_\_\_ Results \_\_\_\_\_

**Developmental History:** Please give the approximate age when your child:

Walked alone \_\_\_\_\_ Spoke in sentences \_\_\_\_\_ Was toilet trained \_\_\_\_\_ Dressed self \_\_\_\_\_

How does this child's development compare to other children, such as brothers/sisters or playmates?

About the same \_\_\_\_\_ Delayed \_\_\_\_\_ Advanced \_\_\_\_\_

Student Name: \_\_\_\_\_

**Health Conditions:** Please check any that your child has or had

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Allergies                      | <input type="checkbox"/> Chickenpox                | <input type="checkbox"/> Juvenile Arthritis          |
| <input type="checkbox"/> Anaphylactic reaction          | <input type="checkbox"/> Cystic Fibrosis           | <input type="checkbox"/> Meningitis/Encephalitis     |
| <input type="checkbox"/> Asthma or wheezing             | <input type="checkbox"/> Diabetes                  | <input type="checkbox"/> Seizures/Epilepsy           |
| <input type="checkbox"/> Attention Deficit Disorder     | <input type="checkbox"/> Ear problems/poor hearing | <input type="checkbox"/> Sore throat (frequent)      |
| <input type="checkbox"/> Behavior/Emotional concerns    | <input type="checkbox"/> Eczema/skin conditions    | <input type="checkbox"/> Speech difficulties         |
| <input type="checkbox"/> Birth/Congenital malformations | <input type="checkbox"/> Eye problems/poor vision  | <input type="checkbox"/> Toothaches/dental problems  |
| <input type="checkbox"/> Blood problems                 | <input type="checkbox"/> Headache (frequent)       | <input type="checkbox"/> Urinary tract infections    |
| <input type="checkbox"/> Bone/Joint problems            | <input type="checkbox"/> Heart Disease             | <input type="checkbox"/> Wetting during day or night |
| <input type="checkbox"/> Bowel problems                 | <input type="checkbox"/> Hepatitis                 |  |
| <input type="checkbox"/> Cancer                         |  |  |

**Illness, Injuries & Hospitalizations (please explain):**

\_\_\_\_\_

**Medical Home:** Please provide us with your child's current health care provider's name and contact information.

Physician Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

**Current Health:** Tell us about any current health conditions or concerns:

\_\_\_\_\_

**Allergies:** If your child has any food or environmental allergies, please obtain the Allergy Action Plan form from the school clinic for your child's health record.

Allergy	Reaction	Treatment

**Medications:** Describe medicine your child takes regularly. If your child must take medication at school, please obtain the Medication Administration Authorization form from the school clinic to be completed by you and your child's doctor.

Medication	Reason	How often?	What time?

Explain any special assistance your child may need during the school day:

\_\_\_\_\_

Please add any comments or concerns you have about your child's health, development, behavior, family or home life that you would like the school to be aware of:

\_\_\_\_\_

If you have questions or concerns about your child's health or would like information about a medical home for your child or community services that may be available, please contact your school clinic.

\_\_\_\_\_  
Signature of parent/guardian completing form

\_\_\_\_\_  
Date

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

VACCINES	<i>FALL 2011</i> IMMUNIZATIONS FOR CHILD CARE/HEAD START AND PRE-SCHOOL ATTENDANCE	<i>FALL 2011</i> IMMUNIZATIONS FOR SCHOOL ATTENDANCE
<b>DTaP/DTP/DT Tdap/Td</b> Diphtheria, Tetanus, Pertussis	4 doses of DTaP, DTP, or DT or any combination.	<b>Kindergarten</b> 5 doses of DTaP, DTP, or DT, or any combination, if the fourth dose was administered prior to the 4 <sup>th</sup> birthday <b>Grades 1-12</b> 3-4 doses of DTaP, DTP, DT or Td or any combination. <b>Grades 7-8</b> 1 dose of Tdap or Td vaccine must be administered prior to entry.
<b>POLIO</b>	3 doses of OPV or IPV or any combination of OPV or IPV.	<b>K-1</b> A minimum of 3 doses. The final dose must have been given on or after the 4 <sup>th</sup> birthday, regardless of the number of previous doses; 4 doses if a combination of OPV and IPV was administered. <b>Grades 2-12</b> 4 doses if a combination of OPV and 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 <sup>th</sup> birthday.
<b>MMR</b> Measles, Mumps, Rubella	1 dose of MMR administered on or after the first birthday	<b>K-12</b> 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.
<b>Hib</b> <i>Haemophilus Influenzae</i> Type b	3 or 4 doses depending on the vaccine type, the age when the child began the 1 <sup>st</sup> dose and the last dose must be after 12 months <b>or</b> 1 dose if given on or after 15 months of age	<b>None</b>
<b>HEP B</b> Hepatitis B	3 doses of Hepatitis B	<b>K-12</b> 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.
<b>Varicella</b> (Chickenpox)	<b>None</b>	<b>K-1</b> 2 doses of varicella vaccine must be administered prior to entry. <b>Grade 2-5</b> 1 dose of varicella vaccine must be administered on or after the first birthday.

### NOTES:

- The 4 day “grace” period applies to all age and interval minimums. If MMR and Varicella are not given on the same day, the doses must be separated by at least 28 days with no grace period.
- The 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.