2018-2019

Please refer to the notes below before filling out the enrollment forms.

Please be advised:

- **Students who have and/or had a pending case in the juvenile/adult court system due to legal offenses must first submit documentation for administrative review prior to submitting an enrollment or re-enrollment packet.**
- **Visible body piercings and/or tattoos are not allowed at EDCS.**
- **The EDCS office no longer takes teacher requests for those enrolling or re-enrolling.**
- **Parents/Guardians need to read the Parent-Student Handbook in order to sign the statement of cooperation that is on the bottom of the student information page. The handbook is located at eastdaytonchristian.org under the parent portal on the homepage.**

Thank you!

EAST DAYTON CHRISTIAN SCHOOL NEW ENROLLMENT CHECKLIST K-12
2018-2019

Check (√) each item as you complete. Bring completed forms to the school office with fees.

New Students:

_____Registration fee: $100
All students must pass an entrance exam to be accepted.

_____Enrollment Application Form

_____Custody Verification Papers are included (if applicable)

_____Copy of official stamped Birth Certificate (not Hospital record; must have by testing)

_____Student Medical Exam **(Due Aug. 1st)**

_____Immunization Record **(Due Aug. 1st) Must have in order to attend the 1st day of school.**

_____Medical Forms (Health History Form & EMA) **(Due Aug. 1st)**

_____K-8 Daycare Forms (if applicable)

_____Principal Recommendation Form

_____Honor Code, Statement of Faith, Partnership Agreement, Conflict Resolution Policy, and Extended Daycare information is in the EDCS Parent/Student Handbook.
_____Financial Forms

_____*Parent/Administration interview (to be scheduled)* _____*Kindergarten only: Supply kit fee*

Returning Students:

_____Registration fee: $50 until Fri. 2/16/2018; $100 beginning Tue. 2/20/2018
_____Enrollment Application Form
_____Honor Code, Statement of Faith, Partnership Agreement, Conflict Resolution Policy, and Extended Daycare Information is in the EDCS Parent/Student Handbook.
_____"I certify that all family/student information has been reviewed by me before submitting this application, and everything is correct/current on RenWeb." **initial**_____
_____"The office has the most up-to-date custody paperwork." **initial**_____
_____Financial Forms

All Students:

For all families *applying for a state tuition voucher*:

If you are applying for the Ohio EdChoice scholarship (voucher), please check one:

_____ **I am a new applicant.** _____ I am a renewal.

For Military families only, if you receive orders **on or before July 1, 2018**, enrollment fee will be refunded. Please bring orders to the school office.

COMPLETE: _____ **(Office use only)**
(*Incomplete packets will be returned for completion.)*

STUDENT INFORMATION

☐ New Student ☐ Returning Student

Applicant Name _____ Date of Birth _____
Last First Middle

Preferred Name _____ ☐ Male ☐ Female

Student Address: _____
Street City, State Zip Country

Home phone number _____

Ethnicity: ☐ African-American ☐ Asian Hispanic/Latino ☐ American Indian/Alaska Native ☐ Caucasian
☐ Multiracial ☐ Native Hawaiian/Pacific Islander ☐ Other _____

New Students Only:

Grade to Enter 2018-19 _____ Current School _____
☐ ☐ ☐ ☐

Has student been retained, suspended, expelled, or asked to withdraw? If so, what grades? Please Explain.

_____

Has your child ever been a student at East Dayton Christian School? _____When? _____

Check grades previously attended: ☐ K4 ☐ K5 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐10 ☐11

All Students: If your student wasn't enrolled in EDCS, what public school would your student attend? _____

Name and grade of other children attending our school: _____

Public school district in which you currently live: _____

Family Status ☐ 2 Parent Family ☐ Single Parent Family ☐ Legal/Joint Custody

Legal Custodian/Guardian ☐ Parents (Same Household) ☐ Father ☐ Mother ☐ Other _____

Military Family: ☐ YES ☐ NO

Church Affliation: _____ **Church Member** ☐ YES ☐ NO

Does your child have any medical conditions or history of unusual physical or emotional condition which required professional attention? Please Explain _____

Is your child currently taking any medications? Describe: _____

_____ Physician _____

Phone _____

School recommended by: _____Reason for selecting this school _____

Emergency contacts: (Please list name/relationship to student and best phone numbers to call)

Name/Relationship: _____ Phone: _____

Name/Relationship: _____ Phone: _____

****

Is your student currently receiving or ever received special education/intervention services? ☐ Yes ☐ No

Is your student presently receiving speech services? ☐ Yes ☐ No

Is your student currently on an IEP/504 Plan/MEP? ☐ Yes ☐ No

*If yes, please include with completed application for admission.

**If no, have they been on a plan in the past? ☐ Yes ☐ No

STATEMENT OF COOPERATION

In making application for my child, it is my desire to have him complete the school year 20__-20__. It is also my understanding that the policy of the school is to make no refunds on registration fees. I also give permission for my child to take part in school activities, including sports and school sponsored trips away from the school premises, and absolve the school from liability to me or my child because of any injury to my child at school or during school activities. I have read and agree to abide by the policies in the East Dayton Christian School parent/student handbook which includes, but is not limited to: EDCS Honor Code, Partnership Agreement, and Conflict Resolution. **(The parent/student handbook is located at eastdaytonchristian.org under the parent portal on the homepage.)**

Parent Signature _____ Parent Signature _____

PARENT INFORMATION FORM

Father (Legal Custodian/Guardian)

Name _____

Address _____

_____

Employer _____

Position _____

Work Phone _____

Cell Phone _____

Email _____

Mother (Legal Custodian/Guardian)

Name _____

Address _____

_____

Employer _____

Position _____

Work Phone _____

Cell Phone _____

Email _____

Marital Status: □ Married □ Separated* □ Divorced* □ Single*

**** If custody has been awarded to one parent or is shared, a copy of that document must be included with this application.***

_____ Please check if your home address above has changed since the 1st day of school.

Student Lives With:

☐ Both Parents ☐ Mother only ☐ Father only ☐ Guardian ☐ Mother and Step-Father

☐ Father and Step-Mother ☐ Foster Parents ☐ Other _____

Non-residential/Non-custodial parent (if applicable)

Name _____ Relationship_____

Address _____

_____

Home Phone _____ Cell Phone _____

Email _____

Does non-residential/non-custodial parent have visitation rights? □ Yes □ No

Does non-residential/non-custodial parent responsible for tuition? □ Yes □ No

Step-Parent Information (if applicable)

Legal Step-Father's Name _____ Phone: _____

Legal Step-Mother's Name: _____ Phone: _____

*East Dayton Christian School does not discriminate on the basis of race, color, national and ethnic origin in admissions policies, scholarships, athletic and other school-administered programs. EDCS reserves the right to select students on the basis of academic performance, religious commitment, lifestyle choices, and personal qualifications including a willingness to cooperate with EDCS administration and to abide by its policies. (Romans 2:11) Revised 12/15

EAST DAYTON CHRISTIAN FINANCIAL CONTRACT

Parent/Guardian(s) Name:_____
Address:_____
City_____**State**_____**Zip**_____
Telephone (hm)_____**(wk)**_____**(cell)**_____
Email_____

Student's Name:	**Grade to enter:**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Contract decision for the 2018-2019 school year:

_____ I will pay an annual payment due July 15, 2018. (5% discount)
_____ I will pay an annual payment due August 1st, 2018. (4% discount)
_____ I will pay 2 semi-annual payments due July 15, 2018 & Dec. 1, 2018. (3% discount)
_____ I will use the FACTS 10 month payment plan Aug. 2018- May 2019.
_____ I will use the FACTS 12 month payment plan June 2018- May 2019.
_____ I need Day Care for my child(ren).
_____Add my payment to my FACTS agreement
_____ Monthly payment will be made to the school office
_____ Add my payment to my Annual or Semi-Annual bill
_____ I receive an Ohio Ed Choice Voucher.
_____ I am applying for the Ohio Ed Choice Voucher.
_____ I have a full-time student(s) at EDCS Preschool.

Please list student(s) name(s).

_____

_____

Comments:_____
_____
_____
_____

I agree to make tuition payments for the 2018-2019 school year according to one of the options above.

_____ _____
Responsible Parties Signature **Date**

_____ _____
Authorized School Signature **Date**

EAST DAYTON CHRISTIAN SCHOOL TUITION ASSISTANCE
999 Spinning Rd.
Dayton, Ohio 45431
(937) 252-5400

EAGLE SCHOLARSHIP FUND

For families not receiving a scholarship or tuition vouchers.

For any family applying, $250.00 will be applied toward tuition per student in grades K through 12.

Family Name:_____ Student Name/Grade:_____
Address: _____ _____
_____ _____
_____ _____
Phone Number:_____ _____

I receive a scholarship or tuition voucher from an outside source _____yes _____no.
I would like to receive the Eagle scholarship _____yes _____no.

EMERGENCY TUITION ASSISTANCE

For families not receiving a scholarship or tuition vouchers.

For any family verifying a financial need, East Dayton Christian School reserves the right to award additional scholarship funds as they become available.

Family Name:_____ Student Name/Grade:_____
Address: _____ _____
_____ _____
_____ _____
Phone Number:_____ _____

Please attach W-2 FORMS. The business office will contact you.

EDCS East Dayton Christian School

EMERGENCY MEDICAL AUTHORIZATION

2018-2019

Please **PRINT IN INK** or **TYPE** and complete all blanks.

Name of Student_____ Birthdate_____
Homeroom Teacher_____ Room #_____ Grade_____ School Year_____

Names of Parents/Guardians_____
Home Address_____City_____State___
Zip Code_____ School District_____ Email address_____
Home Phone_____ Cell Phone_____

Siblings at EDCS Names/Grades_____

Place of Employment for Parents/Guardians:

Father_____ Phone_____ Ext_____
Mother_____ Phone_____ Ext_____

<u>Authorized persons</u> to assume responsibility for school dismissal and provisions of care when a parent/guardian cannot be reached:

1._____Phone_____ Relationship_____
2._____Phone_____ Relationship_____

Family Physician or Pediatirician_____
Address_____
Phone_____

Family Dentist_____
Address_____
Phone_____

Local Hospital Prefernce_____
Address_____
Insurance that applies to child_____ Policy #_____

Relevant medical factors <u>including allergies</u> _____
Medications_____
Physical Impairments_____

<u>COMPLETE BOTH SIDES</u>

1. **CONSENT FOR EMERGENCY MEDICAL TREATMENT**

In the event reasonable attempts to contact me/us have been unsuccessful, I/we hereby give my/our consent for administration of any treatment deemed necessary by Dr._____(preferred doctor) available, another doctor or dentist; and the transfer of the student to the above stated hospital or any hospital reasonable accessible. This authorization doesn't cover major surgery unless the medical opinions of two (2) other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Signatures of Parents/Guardians_____
Date_____

---

2. **CONSENT FOR EMERGENCY TRANSPORTATION**

In the event my/our child needs to be transported by ambulance or emergency vehicle, I/we authorize transportation.

Signature of Parents/Guardians_____
Date_____

---

3. **REFUSAL TO CONSENT**

NOTE *Do NOT complete Part 3 if you have completed Part 1.*
I/We do not give my/our consent for emergency medical treatment of my/our child. In the event of illness or injury requiring emergency treatment, I/we wish the school authorities to take no action, or to_____

Signature of Parents/Guardians_____
Date_____

RECORDS RELEASE FORM

Request for Release or Transfer of School (Academic & Discipline), Health, and Psychological Records to East Dayton Christian School

Parents, please *complete your student's current school address completely*. Without a complete address, records cannot be requested. Without records, enrollment is considered incomplete.

Name of Student: _____SSID #_____

Date of Birth: _____Current Grade: _____

School last attended:_____

Address:_____

City: _____ State: _____ Zip Code: _____

_____	_____	_____
Date	**Legibly Printed Name**	**Phone**

_____

Signature of parent or legal guardian

Please release or transfer the above named student's records to the address below:

East Dayton Christian School
999 Spinning Rd.
Dayton, OH 45431

OR

Name of School/Doctor: _____

Address: _____

City: _____State: _____Zip Code: _____

Parents/guardians may inspect the records transferred or received. Records transferred by authorization of this release will NOT be released to another person, out-of-district school, or agency other than the one listed above without written notification to the parent or guardian.

Attn: Principals

Please send appropriate records including:

1. Past grade history
2. Standardized test scores
3. Discipline and attendance records
4. IEP and ETR/504 Plan if applicable
5. Transcripts
6. Student Recommendations For Admission

Send Student Records to:
East Dayton Christian School
Kathy Wayman
999 Spinning Rd.
Dayton, OH 45431
Fax: 937-258-4099
kwayman@eastdaytonchristian.org

EDCS

Equipping for Leadership and Service

STUDENT RECOMMENDATION
FOR ADMISSION TO EAST DAYTON CHRISTIAN SCHOOL
999 Spinning Rd., Dayton, OH 45431

INSTRUCTIONS TO PARENTS: Please complete items 1-4, then give this form to your student's principal or other authorized officer at his/her school. Your signature releases records and other evaluative data to East Dayton Christian School. *Registration is not complete without this information.*

(1) **Student's Name** _____

(2) **Applying to grade** _____ (3) **Date** _____

(4) **Signature of Parent/Guardian**_____

This section is to be completed by the student's school principal or other authorized officer. This form assists in screening new applicants. The information gathered may or may not be shared with the student's parents/guardians. Principal should return form directly to East Dayton Christian School by mail or fax, 937-258-4099.

Name of School _____

How many years did the student attend? _____ What grades? _____

Reason for transfer: _____

Principal's Name _____

** If student has attended current school for less than 2 years, on a separate sheet of paper, please include student's previous school information including, name, address, phone number, principal's name, years attended, grade levels and reason for transfer.*

Please answer the following questions regarding the above named student:

Does this student exhibit recurring disciplinary concerns? _____ Yes _____ No If yes, please explain:

_____

To your knowledge, does this student use illegal drugs, alcohol, and/or tobacco? _____ Yes _____ No

If yes, please explain: _____

Has this student ever been suspended? _____ Yes _____ No If yes, please explain: _____

_____

Has this student ever been expelled **or** asked to withdrawal? _____ Yes _____ No If yes, please explain:

_____

Is this student frequently tardy to school and/or have frequent absences: _____ Yes _____ No

If yes, please explain: _____

Category	5	4	3	2	1	Rating
Integrity	Exceptionally Upright	Noticeably Upright	Upright, no cause to question	Weak or questionable	Record of dishonesty	
Leadership & Responsibility	Outstanding, top positions, contributes most	Commendable, top or next to top positions	Capable, minor positions	No sign or leadership or involvement	Record of irresponsibility	
Interest in Non-Academic Activities	Outstanding	Commendable, top or next to top positions	Active	Minor participation	No participation	
*** Conduct**	Outstanding in every aspect	Generally Excellent	Good or acceptable	Marginal	Poor or reprehensible	
*** Respect for Authority**	Works *very* well with those in authority	Works well with those in authority	Mild resistance to authority	Periodic rebelliousness to authority	Rebellious to authority	
Parental Support	Exceptional	Quite Good	Average	Sometimes Supportive	Often Unsupportive, critical of school	
Summary	Outstanding	Excellent	Good	Fair	Poor	

*** These areas must be filled out by the person in charge of discipline.**

For Private Schools:

Does this student's family take care of their financial obligations to your school in a timely manner?

_____ yes _____ no If no, please explain: _____

_____

Does this student receive an EdChoice Scholarship? _____ yes _____ no

All Schools:

Additional comments about this student: _____

_____

_____

Completed by: _____ Title _____

Phone Number _____ Date _____

EDCS BEFORE/AFTER SCHOOL PROGRAM (One form per student)
2018-2019

Please circle ALL that apply: AM only PM only Both Occasional Full-time

Grade to enter for 2018-2019_____ Gender: ____Male ____Female

Mailing Address_____
Street City Zip

Home Phone_____ Email address_____

With whom does the student reside: Parents Father Mother Guardian

Legal Guardian #1 (Name)_____Relation to student_____

Cell #_____ Work #_____

Legal Guardian #2 (Name)_____Relation to student_____

Cell #_____ Work #_____

Emergency Info: Physician _____ Phone_____

Names of other persons authorized to pick up student:

Name_____ Relation to student_____ Phone#_____

Name_____ Relation to student_____ Phone#_____

Name_____ Relation to student_____ Phone#_____

Estimated time of pick-up from daycare:_____

Parent/Guardian Signature_____ Date:_____

East Dayton Christian School

Ohio Department of Health • School and Adolescent Health

Health History

Student's name	Sex	Date of birth
	☐ Male ☐ Female	/ /

Family Health History Please list allergies, heart problems, diabetes, cancer or other serious health conditions.

Father
Mother
Brothers and Sisters

Birth and Developmental History ☐ No unusual birth or developmental history

Did the mother have any unusual physical or emotional illness during this pregnancy? ☐ Yes ☐ No

Was infant born full term? ☐ Yes ☐ No Did the infant have any sickness or problems? ☐ Yes ☐ No

Briefly explain illness or problems.

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

☐ About the same ☐ Delayed ☐ Advanced

Student Health Conditions

☐ **YES,** my child receives regular medical/health care for the following conditions: ☐ **NO** medical conditions

☐ Allergies	☐ Diabetes	☐ Seizure disorder
☐ Asthma	☐ Depression	☐ Sickle cell anemia
☐ ADD/ADHD	☐ Ear problem/hearing difficulty	☐ Skin conditions
☐ Autism	☐ Emotional concerns	☐ Speech problems
☐ Behavior concerns	☐ Headaches	☐ Traumatic brain injury
☐ Birth/congenital malformations	☐ Heart problems	☐ Vision problems (glasses, contacts)
☐ Bone/muscle/joint problems	☐ Hemophilia	☐ Other_____
☐ Blood problems	☐ Juvenile arthritis	☐ Other_____
☐ Bowel/bladder problems	☐ Lead poisoning	☐ Other_____
☐ Cancer	☐ Migraines	☐ Other_____
☐ Cystic fibrosis	☐ Neuromuscular disorder	☐ Other_____

Please explain any conditions above or any reasons for hospitalizations.

Please indicate any allergies your child may have.

Allergy type	Reaction	School restrictions or recommended actions
☐ Bee/Insect		
☐ Food		
☐ Medication		
☐ Other		

Health History continued

Please list any prescription and over the counter medication that your child takes on a regular basis.

Medication and dose	Time	Reason

Do any health and/or medical conditions require school restrictions, modifications, and/or intervention?

☐ Yes ☐ No If YES, please explain.

Does the student require any special procedures and/or treatments for their health condition(s)?

☐ Yes ☐ No If YES, please explain.

Please indicate any other information about your child's health or development that you think would be helpful for the school to know.

Form completed by	Relationship to student	Date
		/ /

EAST DAYTON CHRISTIAN SCHOOL

PARENT REQUEST & AUTHORIZATION TO ADMINISTER MEDICATION (Prescribed or Over-the-Counter)

Student Name: _____ Address: _____

School: _____ Grade: _____ Teacher: _____

Name of Medication _____ Dosage _____Time(s)_____

PART I

TO THE PARENT/GUARDIAN: Students needing medication are encouraged to receive the medication at home whenever possible. The following information is necessary for any student who must take medication in school. All prescribed and over-the-counter medication must be accompanied by both Parent/Guardian and Licensed Prescriber authorizations.

By signing the form, the parent/guardian agrees to the following:

I will assume responsibility for the safe delivery of the medication to school in a properly labeled container: Prescription medication will be in a prescriber/licensed pharmacist-labeled container that includes the student's name, name of the medication, date, and dosage instructions (quantity and time) and prescriber's name. Over-the-counter medication will be in its original container with all labeling visible.

I will submit a new medication authorization form for each medication with parent and prescriber signatures at the beginning of each school year, and if the previous order changes during the school year.

For students transferring from other school districts: I understand that new medication authorization forms must be written by my licensed provider for EDCS. (Orders written for other school districts are not accepted.)

I release and agree to hold EDCS, its officials, and its employees harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization.

I authorize my child to receive the prescribed medication. I also authorize the exchange of information between the medication's Licensed Prescriber and the school regarding the health care needs of my child when deemed necessary by school personnel. I understand the School Nurse cannot provide or delegate the assistance with administration of this medication without this permission as determined by the Ohio Nurse Practice Act.

Signature of Parent/Guardian: _____ Date: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Emergency Phone Numbers

WHEN AN EPI-PEN* IS ORDERED, I understand I must provide <u>TWO</u> for use at school as required by Ohio law. (ORC 3313.718)

The principal or school nurse has been provided a back-up dose of the *Epinephrine Auto-Injector (Epi-Pen or other type)

Please initial: **YES**_____ / Date _____ **NO**_____ Expiration Date of Medication _____

PERMISSION TO CARRY <u>ASTHMA INHALERS*</u> & <u>EPI-PEN TYPE AUTO-INJECTORS*</u>

PART II

NOTE: The Licensed Prescriber must complete the "Permission to Carry" section of the Medication Authorization on the reverse side of this form. All requested information must be provided before we are able to permit your child to carry their emergency medication.

My child has permission to carry and self administer this medication.

I understand that students who are authorized to self-administer must carry their medication* on their person. I also understand that any irresponsible actions regarding the “self-administration of medications” will be subject to disciplinary action.

Signature of Parent/Guardian: _____ Date: _____

EAST DAYTON CHRISTIAN SCHOOL

PHYSICIAN / LICENSED PRESCRIBER MEDICATION AUTHORIZATION (Prescribed or Over-the-Counter)

PRESCRIBER: EDCS urges you to schedule medication administration times outside of school hours, whenever possible. When necessary, medication administration will be permitted, insofar as feasible, during the school hours.

Part I **MEDICATION ORDER BY LICENSED PRESCRIBER**

(One medication per sheet)

Name of Student: _____ DOB: _____

Medication _____ Dosage _____ Time (s) _____ Route_____

Beginning date: _____ End date: _____ Today's Date: _____

Special Instructions:

_____

Possible adverse reactions for the student the medication was prescribed (that should be reported to the prescriber):

_____

Possible adverse reactions for unauthorized user:_____

Procedure for EDCS employees if the expected relief is not produced or student is unable to administer the medicine:

_____

Prescriber's Signature: _____ **Office #:_____ Fax #: _____**

Prescriber's address: _____ **Emergency #:** _____

ASTHMA INHALERS AND EMERGENCY AUTO-INJECTORS:

Part II **PERMISSION TO CARRY** **ASTHMA INHALER**

This student is capable of possessing and using the inhaler: YES** _____ NO _____ (if NO, inhaler will be kept in the clinic.)

This student has been trained on the proper use of the inhaler: YES** _____ NO _____ (if NO, inhaler will be kept in the clinic.)

**If the prescriber or school nurse determines the student to be incapable of possession or self-administration, the auto-injector will be stored and administered as deemed appropriate by school officials and outlined in the student's Emergency Action Plan.

PRESCRIBER SIGNATURE: _____ DATE: _____

Part III **PERMISSION TO CARRY** **EPINEPHRINE AUTO-INJECTOR**

NOTE: SCHOOL PERSONNEL WILL CALL 911 WHEN AN EPINEPHRINE AUTO-INJECTOR IS ADMINISTERED.

Allergen and/or Circumstances for use of the auto-injector:_____

This student is capable of possessing and using the auto-injector: YES** _____ NO _____

This student has been trained on the proper use of the auto-injector: YES** _____ NO _____

I understand I must prescribe two auto-injectors for use at school as required by ORC 3313.718: YES_____

**If the prescriber or school nurse determines the student to be incapable of possession or self-administration, the auto-injector will be stored and administered as deemed appropriate by school officials and outlined in the student's Emergency Action Plan.

PRESCRIBER SIGNATURE: _____ DATE: _____

Part IV **TO BE COMPLETED BY THE SCHOOL**

Date Received:_____ Signature of Administrator:_____

Person(s) authorized to give medication for this student: Principal, Secretary, Staff Member(s)_____

Signature of School Nurse:_____DATE: _____

East Dayton Christian School

Ohio Department of Health • School and Adolescent Health

Physical Examination

Student's name	Sex ☐ Male ☐ Female	Date of birth / /

Height	Weight	BMI percentile	BP

Screening Tests

Vision

Date performed / /

Distance Acuity	☐ R	☐ L
Muscle Balance	☐ Pass	☐ Fail
Stereopsis	☐ Pass	☐ Fail
Color	☐ Pass	☐ Fail
Child wears glasses?	☐ Yes	☐ No
Tested with glasses?	☐ Yes	☐ No
Referral made?	☐ Yes	☐ No

Hearing

Date performed / /

Pure Tone		
Right ear	☐ Pass	☐ Fail
Left ear	☐ Pass	☐ Fail
Child wears hearing aid?	☐ Yes	☐ No
Child under the care of a hearing specialist	☐ Yes	☐ No
Referral made?	☐ Yes	☐ No

Postural

Date performed / /

☐ No abnormality noted
☐ Screening not done
☐ Referral made
Comments
_____
_____
_____

Speech/Language

Speech assessment completed	☐ Yes	☐ No
Child has no discernible speech problem	☐ Yes	☐ No
Speech evaluation recommended	☐ Yes	☐ No

Child has possible problem with _____

Lead Poisoning

☐ Date _____ Type ☐ C ☐ V Results_____ µg/dL
☐ Date _____ Type ☐ C ☐ V Results_____ µg/dL

Tuberculin Test

Date_____ Type _____ Results_____

Health History (Serious or chronic illnesses/injuries/surgeries)

_____

Physical Examination Date of most recent examination / /

☐ Essentially normal ☐ Abnormalities as follows

_____

_____

Is this child able to participate fully in:

Classroom and academic activities	☐ Yes	☐ No	Physical education classes	☐ Yes	☐ No
Competition athletics	☐ Yes	☐ No	Contact and collision sports	☐ Yes	☐ No

If limitations are advised, please specify

_____

_____

Does this child have any physical, developmental or behavioral issues that may affect his/her educational process?

_____

_____

HealthCare Provider's signature	Print name	Phone ( )
Address		Date / /
City	State	ZIP

HEA 4242 8/06

East Dayton Christian School

Ohio Department of Health • School and Adolescent Health

Immunization Report

Student's name	Sex	Date of birth
	☐ Male ☐ Female	/ /

Students are required to be immunized in accordance with Ohio law (Ohio Revised Code 3313.67/3313.671).
A copy of the child's immunization record may be attached or dates may be entered below.
Please note the month, day, and year for each immunization should be on record.

Vaccine	**Record complete dates** (month, day, year) **of vaccine doses given**					
Diphtheria, Tetanus, Pertussis (DTP)						
DTaP, Tdap						
DT, Td						
Polio						
Hepatitis B (HBV)						
Measles, Mumps, Rubella (MMR)						
Varicella (Chickenpox)						
Hepatitis A						
Meningococcal (MCV4, MPSV4)						
Pneumococcal (PCV)						
Measles (Rubeola) only						
Rubella only						
Mumps only						
Haemophilus influenza Type b (Hib)						
Influenza						
Other						

This information was provided by ☐ Health Care Provider ☐ Parent/Guardian ☐ Other _____

Signature	Print name	Date
		/ /

HEA 4241 8/06

Authorization to Disclose Immunization Information

Name of Child_____ Date of Birth_____

I, _____, as the parent or guardian of the above named child, hereby authorize *(Name of Provider[s])*:

_____

_____

to disclose the specific and individually identifiable immunization records of the above named child to *(Name of School)*:

_____

for the specific purpose of presenting written evidence, satisfactory to the person in charge of admission, that the above named child has been immunized by a method of immunization approved by the department of health as required by section 3313.671 of the Ohio Revised Code.

This authorization will expire upon the presentation of written evidence sufficient to comply with section 3313.671 of the Ohio Revised Code or for the period of time needed to fulfill its purpose. I also understand that I may revoke this authorization, in writing, at any time and that I may be asked to sign the *Revocation Section* on the back of this form. I further understand that any action taken by the above named Provider(s) or School in accordance to this authorization prior to it being revoked is legal and binding.

I understand that my information may not be protected from re-disclosure by the requester of the information unless otherwise provided for by state or federal law. Please note: medical records provided to schools that receive federal funding are protected by the Family Educational Rights and Privacy Act (FERPA).

I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given.

I also understand that my refusal to sign this authorization may prevent the school from verifying that the above named child has been immunized. I further understand that if the school cannot verify and I cannot provide satisfactory written evidence that above named child has been immunized, the child may be excluded from school pursuant to section 3313.671 of the Ohio Revised Code.

I further understand that I may request a copy of this signed authorization.

(Signature of Personal Representative)	*(Date)*	*(Relationship/Authority)*

****

NOTE: This Authorization was revoked on:

(Date)	*(Signature of Staff)*

REVOCATION SECTION

I do hereby request that this authorization to disclose immunization information of _____
(Name of Child/Patient)

signed by_____ on _____ be rescinded,
(Enter Name of Person Who Signed Authorization) *(Enter Date of Signature)*

effective _____.
(Date)

I understand that any action taken by the named Provider(s) or School in accordance to this authorization prior to the revocation date is legal and binding.

_____	_____	_____	_____
(Signature of Client/Patient)	*(Date)*	*(Signature of Witness)*	*(Date)*

_____	_____	_____
(Signature of Personal Representative)	*(Date)*	*(Relationship/Authority)*