Lakota Christian School
West Chester, OH 45069

HEALTH INVENTORY

To Parents or Guardians:

The following must be completed for the following:

- A physical examination by a physician or certified nurse practitioner must be completed no more than nine months before or six months after enrollment. A physical examination form designated by the Ohio State Department of Education and the Department of Health must be used to meet this requirement.

- Evidence of immunizations against common childhood communicable diseases is required for all students in pre-kindergarten through 6th grade. An Ohio Immunization Certification form for newly enrolling students may be obtained from the local Department of Health and Human Services or from school personnel. The form and the required immunizations must be completed before a child may attend school.

Exemptions from a physical examination and immunization are permitted if they are contrary to a student's religious beliefs. Students may also be exempted from immunization requirements if a physician certifies that there is a medical contraindication.

The health information on this form will be available only to those health and education personnel who have a legitimate educational interest in your child.

In order to assist your child in gaining the most from his/her educational experience, please complete Part I of this Health Inventory form. Part 2 must be completed by a physician or nurse practitioner, or attach a copy of child's physical examination to this form. If your child requires medication to be administered in school, you must have the physician complete the medication administration form. This form can be obtained from your child's school. If you do not have access to a physician or nurse practitioner or if your child requires a special individualized health procedure, please contact the principal of your child's school.

Please complete this Health Inventory form and return it to your child's school as quickly as possible.

PART 1 - HEALTH ASSESSMENT

To be completed by parent/guardian

____ ____/____/____ _______________

Student Name (Last, First, Middle) *Birth date* *Grade*

____ _______________

Address (Street, City, State, Zip) *Phone Number*

___________________________ ___________________________

Parent/Guardian (Male) *Parent/Guardian (Female)*

____

Physician/Nurse Practitioner Name and Address

____

Dentist Name and Address

____

Other source(s) from which the student receives health care. (If none, write "None.")

ASSESSMENT OF STUDENT HEALTH

To the best of your knowledge, does your child have any problems that may affect his/her learning in school, cause any concern and/or be important for school staff to know?

	Yes	No	Comments
Allergies (Drugs, Food, Insects)			Describe reaction:
Asthma			
Behavior or Emotional Problems			
Birth Defects			
Bladder Problem			
Bleeding Problems			
Bowel Problems			
Cerebral Palsy			
Concussion (Head Injury)			
Diabetes			
Ear Problems or Deafness			
Eye or Vision Problems			
Heart Problems			
Hospitalization (When, Where)			
Lead Poisoning			
Limits on Activity			
Medication			
Meningitis			
Prematurity			
Seizures			
Sickle Cell Disease			
Speech Problems			
AIDs			
Contagious Diseases			

Would you like to discuss your child's health with school personnel? Yes ☐ ☐ No

I give my permission for confidential and discreet use of Part 2, the health evaluation completed by the physician, to meet my child's health and educational needs in school. ☐ Yes ☐ No

____ ____/____/____

Signature, Parent/Guardian *Date*

IMPORTANT: Schedule an appointment for a medical examination of your child; share the above information with the physician, have him/her complete Part 2 after the exam and then return the form to the school.

PART 2 HEALTH EVALUATION

To be completed by physician/nurse practitioner

1. Does this child have a health condition(s) which may require EMERGENCY ACTION while he/she is at school (e.g., seizures, asthma, insect sting allergy, bleeding problem, diabetes, heart problem)? If Yes, describe:

☐ No ☐ Yes ____

2. Is child on long-term technology assistance? ☐ No ☐ Yes ____________________

3. Is there any evidence for concern in the areas listed below? Please check appropriate box.

CONCERN

Health Area	**Yes**	**No**	**Not Evaluated**	**Health Area**	**Yes**	**No**	**Not Evaluated**
Vision				Adjustment			
Hearing				Nutrition			
Speech/Language				Physical Illness/Impairment			
Development				Immunodeficiency			
Attention Deficit/Hyperactivity				Lead Poisoning			

Please explain all yes answers. Include recommendations for referral and treatment.

____

____

____

____

4. Immunizations given on this visit: ☐ DPT/Td #___ ☐ Polio # ___ ☐ MMR # ____ ☐ Other_________

5. Tuberculin Test Results: ☐ Positive ☐ Negative ________ ____/____/____

6. Is the student on long-term medication? If yes, please describe.
☐ No ☐ Yes ____

(Form 500-3: Authorization to Administer Prescribed Medication required if in-school administration)

7. Should there be any restriction of physical activity in school? If yes, specify nature and duration.
☐ No ☐ Yes ____

Student Name (Type/print) ___________________________________ has had a complete history and physical examination at our office and has no evident health problems except as noted above.

______________________________________ ________________

Physician/Nurse Practitioner (Print) *Phone Number*

______________________________________ ____/____/____

Physician/Nurse Practitioner Signature (Original) *Date*

IMPORTANT: Ohio Immunization Certification is required by law. Please attach to this form.