Dear Parent/Guardian,

The State of Ohio requires the parent/guardian of a child entering a preschool program to provide certain health and emergency information ***before*** the child's first day of preschool attendance, unless otherwise noted. The required forms are attached and include:

- **Emergency Medical Authorization (EMA)**
- **Immunization Record (**must submit to the preschool program no later than the first day of school**)**
- **Preschool Health History**
- **Dental Report**
- **Physician's Report** (**Must** be received within thirty (30) days of the first day of attendance) For children three years of age and older, the physical examination must have been completed within twelve (12) months of the first day of attendance and annually thereafter.

Please give the forms to the teachers when they make your home visit. All forms (except the physician's report) must be at the school before the first day of attendance.

The required health and emergency information is in the best interest of every child attending the preschool program. Such requirements provide for the prevention and control of communicable diseases, appropriate management of children with special health needs, and access to parents/guardians or identified responsible adults in cases of emergency.

Thank you for your cooperation in sending your child's information to school by the required deadlines. If you have any questions related to your child's health status or the preschool requirements, please contact your child's classroom teacher or me at 674-4581.

Sincerely,

Susan Geoppinger

Susan Geoppinger, RN
School Nurse
Early Childhood Program
Hamilton County Education Service Center

Dear Healthcare Provider,

The Ohio Department of Education requires all Center Based Early Childhood Programs to include the following information on the health examination forms (i.e., "Healthcare Provider Form"):

-Vision Screening Results
-Hearing Screening Results
-Height
-Weight
-Lead Level
-Hemoglobin Level

If these screenings are not completed during the office visit, we ask that you provide a very brief explanation on the examination form. Please review the attachment: "Healthcare Provider Form" for further details.

Thank you for your assistance.

Sincerely,

Susan Geoppinger

Susan Geoppinger, R.N.
School Nurse
Early Childhood Program
Hamilton County Education Service Center

hamilton county esc

Healthcare Provider Report

Preschool health record

Child's Name	Birthdate:	Sex: Male [ ] Female [ ]

OBJECTIVE DATA

*Height:_______ (%) *Weight:_________ (%) *BMI: ________ (%) B P: _______/______

* Reason Not completed(ex. Healthcare provider decision, insurance coverage, religious conviction) ____________________

SCREENING TESTS

VISION Date * If not completed, please explain below

Screening equipment utilized:________________________

Distance Acuity OD:_20/________ OS:_20/______________

Random Dot E/Stereopsis ☐ pass ☐ fail ☐ not done

Near Acuity ☐ pass ☐ fail ☐ not done

Child wears glasses? ☐ yes ☐ no

Tested with glasses? ☐ yes ☐ no

Referral made? ☐ yes ☐ no

* Reason Not completed(ex. Healthcare provider decision, insurance coverage, religious conviction) ____________________

HEARING Date * If not completed, please explain below

Pure tone testing: 1200, 2000, 4000 (HZ) at 20 Decibles

Right ear ☐ pass ☐ fail ☐ not done

Left ear ☐ pass ☐ fail ☐ not done

Typanometry/Impedance ☐ pass ☐ fail ☐ not done

Other tests (specify)________________________

History of Otitis Media ☐ yes ☐ no // Insertion of PE tubes ☐ yes ☐ no Date: _________

Referral made? ☐ yes ☐ no

Child wears hearing aid? ☐ yes ☐ no

* Reason Not completed(ex. Healthcare provider decision, insurance coverage, religious conviction) ____________________

SPEECH/LANGUAGE

Speech assessment: ☐ Done ☐ Not done ☐ Child has no discernible speech problem

Child has possible problem with: ☐ Articulation ☐ Rhythm ☐ Voice ☐ Language

Speech evaluation recommended: ☐ Yes ☐ No

LABORATORY TESTS/Other tests

☐**Hemoglobin*________ ☐ **Lead level* __________ Atlantoaxial Instability x-ray (required Down Syndrome): Date:________ ☐ Done ☐ Not done ☐ Positive ☐ Negative

*Reason Not completed(ex. Healthcare provider decision, insurance coverage, religious conviction) ____________________

PHYSICAL EXAMINATION:

***Please include an *updated copy* of the immunization records with this form**

Date of examination: _________________ ☐ Essentially normal ☐ Abnormalities as follows: ____________________

Is this child able to participate fully in the following:

A. Classroom and academic activities? ☐ yes ☐ no

B. Gross motor activities such as running, tumbling, climbing, etc.? ☐ yes ☐ no

If limitations are advised, please specify those limitations: ____________________

If this child has any physical, developmental or behavioral problems, how can the school assist with special programs, placement or attention?

____

ASSESSMENT

Problem list:	Recommendation for school management

PLEASE PRINT OR STAMP

Healthcare provider name:	Healthcare provider signature:
Address	
Phone	Date signed