Wellington

Dear New Family (Little Jags and PK),

Welcome to Wellington! The forms in this packet give me information about your child's health, so I can provide the very best care.

Please complete these forms according to the schedule listed below and return them to me, the division office, or drop them off in the Admissions Office. Ohio law requires that parents provide the immunization record and a copy of the birth certificate of each new student, prior to the first day of school.

Page	Name of Form	Who Com	pletes When Is It Due
Page 1	School Health Record	Parents	Before 1st Day of School
Page 2	Immunizations and	Healthcare	Before 1st Day of School
	Physical Exam	provider	
Page 3	Emergency Information	Parents	Before 1st Day of School
Page 4	Dental Exam (optional)	Dentist	Whenever possible
Not in	Copy of Birth Certificate	Parents	Before 1st Day of School
packet		provide	
		сору	

At the beginning of this school year, you will be asked to complete an electronic emergency contact form. It is important that this be completed quickly, in the event that your child is ill or injured at school.

Please contact me if I can be of assistance with any health concern.

Sincerely,

Kim Dunn RN, BSN, MS Licensed School Nurse 614-324-1661

Wellington School Health Record

Child's Name (Last, First, Middle)	Date of Birth	Grade
Is there anything about your child that we need to know	to better understand	him / her?
List any diseases, serious injuries, allergies or asthma tha	t your child has had a	nd give dates (year only).
List any medications or treatments your child receives at	home. Are any requi	red at school?

The Wellington School Physical Exam Report

(A physical exam is required for new, Little Jag, and PK students only)

Student's Name				Grade		
Healthcare provide	er, check on	e:				
	•	nin normal lim	nits			
	rmalities as f					
Can student carry	_	_	ool work?			
Yes No						
Restrictions:						
Healthcare Provide	er's Signatu	re			Date	
IMMUNIZATIONS			A separate list may be attached.			
DTaP/DT/Td	Mo Day Yr	Mo Day Yr	Mo Day Yr	Mo Day Yr	Mo Day Yr	Mo Day Yr
Polio		/ /	//	/ /	//	
	/ /	/ /	//	/ /	//	//
Hepatitis B	/ /	/ /	//	/ /	/ /	//
MMR	/ /	/ /	/ /	/ /	//	//
Varicella	/ /	/ /	/ /	/ /	//	
Tdap (7 th grade)	/ /	/ /	/ /	/ /	/ /	
Meningococcal	/ /	/ /	/ /	/ /	/ /	/ /
7 th & 12th						
	/ /	/ /	/ /	/ /	//	/ /
	/ /	/ /	/ /	/ /	/ /	/ /
	/ /	//	1 1	/ /	/ /	/ /
	/ /	//	1 1	/ /	/ /	/ /
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	/ /	/ /	/ /	/ /	/ /	/ /
	/ /	/ /	/ /	/ /	/ /	/ /
Screening Tests		Date			Results	
Muscle Balance						
Farsightedness						
Color						
Distance Acuity				Ris	ght Le	eft
,						
Hearing				Ris	ght Le	eft
Ü						
		I.		2		

THE WELLINGTON SCHOOL EMERGENCY INFORMATION

Part I							
Student		Date of Birth/					
Parents		Home Phone					
Address	City_	Zip					
Parent #1 Business Phone	Pa	rent #1 Cell					
Parent #2 Business Phone							
Part II EMERGENCY CO	EMERGENCY CONTACTS IF PARENTS CANNOT BE REACHED (please complete all lines) o care for your child if you are not available (relative, friend)?						
1	•	nive, menuj:					
Address		Phone					
2							
Address		Phone					
	MEDICAL HISTORY						
List health conditions							
Medications							
Asthma? (Circle One) Yes No	Will your child carry an ir	nhaler at school? (Circle One) Yes No					
Medications for asthma		,					
Allergies? (Circle One) Yes No							
To what is child allergic?							
Symptoms caused by allergy							
Treatment for allergy							
Physical impairments							
Additional information							
In the event of a serious emergency, 911 will parent. If reasonable attempts to contact money consent for (1) the administration of any treat event the preferred practitioner is not availated and (2) the transfer of my child to any hospit agree that it is necessary to proceed without students beyond the administration of first a	be called immediately a e at the above telephone atment deemed necessar ble, I give consent to trea al reasonably accessible; me. The school cannot						
Parent Signature		Date					
I hereby give consent for the following medic		cal hospital to be called:					
Physician							
Address		one					
Dentist							
Address		one					
Hospital							
	FOR PAIN RELIEVER IF N ster a pain reliever (Tylen	EEDED (K-12) nol or ibuprofen) to my child, if needed, in the					
Parent Signature		Date					

The Wellington School Dentist's Report

Student's Name	Grade	
The following services have been performed: (Please check all that apply)		
Radiographs		
Oral prophylaxis		
Fluoride treatment		
Restorations		
The following statements are applicable: (Please check all that apply)		
All necessary services have been performed		
No restorative services are required at this time		
Further treatment is indicated		
Future appointments have been arranged		
Comments:		
Dontiet's Signature		
Dentist's Signature	Date	