ST. MICHAEL SCHOOL MEDICAL AND DENTAL RECORDS

It is the policy of St. Michael School that each student entering St. Michael School provides MEDICAL and DENTAL examination records. This policy agrees with the American Academy of Pediatrics and the American School Health Association. The Ohio State Department of Health requires upon entrance to the school certain immunizations and other health requirements. The following records must be completed for students to be fully registered with St. Michael School:

1. Proof of Live Birth from the state in which child was born
2. Immunization Requirements for School – See reverse
3. Medical exam by a physician given within one year prior to enrollment
4. Dental exam by a dentist given within one year prior to enrollment

There are medical and dental forms enclosed to be completed by your family physician and dentist.

PLEASE NOTE: Immunization Record, Dental Form, copy of original Birth Certificate, and Baptismal Certificate must be turned in to the School Office prior to the first day of school. If these records are not returned by this date, your child will be unable to attend St. Michael School until such records are secured.

ST. MICHAEL SCHOOL STANDARD DENTAL FORM

PLEASE RETURN THIS COPY TO SCHOOL

Student's Name: _____

Date of Birth: ____ / ____ / _____ Sex: □ Male □ Female

School: _____ Grade: _____

REPORT OF DENTAL EXAMINATION

This is to certify that I have examined the teeth of the above-named student:

- Oral hygiene is: □ Good □ Fair □ Poor
- Number of filled teeth: _____
- Number of extracted teeth: _____
- All necessary dental work has been completed: □ Yes □ No
- Treatment is in progress: □ Yes □ No □ N/A
- The child is under regular dental supervision: □ Yes □ No

REMARKS

Please elaborate on any of the above or make any recommendations that would assist the school in helping this child below:

_____

_____

_____

_____

Dentist's Signature: _____ Date: ____ / ____ / _____

Office Address: _____

Office Phone: (_____) _____ - _____

ST. MICHAEL SCHOOL MEDICAL EXAMINATION FORM

PLEASE RETURN THIS COPY TO SCHOOL WITH CURRENT IMMUNIZATION RECORD ATTACHED

Student's Name: _____

Date of Birth: ____ / ____ / _____ Sex: □ Male □ Female

School: _____ Grade: _____

REPORT OF PHYSICAL EXAMINATION

<table>
<tr><td>HEIGHT:</td><td rowspan="2">ANY MEDICAL CONCERNS REGARDING THE FOLLOWING:</td></tr>
<tr><td>WEIGHT:</td></tr>
<tr><td>BLOOD PRESSURE:</td><td>Mental/Emotional:</td></tr>
<tr><td>PULSE:</td><td>Musculoskeletal:</td></tr>
<tr><td>HEARING: □ Pass □ Fail</td><td>Ear/Nose/Throat:</td></tr>
<tr><td>VISION: □ Pass □ Fail</td><td>Skin:</td></tr>
<tr><td>CHRONIC CONDITIONS:</td><td>Lymph Nodes:</td></tr>
<tr><td rowspan="5">□ ADD/ADHD
□ Asthma
□ Autism/Asperger's
□ Diabetes: □ Type 1 □ Type 2
□ Allergies: _____
□ History of Concussion, date: _____</td><td>Heart/Circulatory:</td></tr>
<tr><td>Lungs/Respiratory:</td></tr>
<tr><td>Stomach/Digestive:</td></tr>
<tr><td>Urinary:</td></tr>
<tr><td>Bowels:</td></tr>
</table>

Please describe any significant medical problems or restrictions:

_____

_____

_____

Physician's Signature: _____ Date: ____ / ____ / _____

Office Address: _____

Office Phone: (_____) _____ - _____