

# Tiffin City Schools

## Kindergarten School Health Records

It is required by Ohio State Law that children entering kindergarten present a record of immunizations by their first day of school. Except in certain instances, no pupil, at the time of his/her original entry or at the beginning of each school year, may be permitted to remain in school for more than fourteen days unless he/she presents written evidence that he/she has been immunized against mumps, polio-myelitis, diphtheria, pertussis, tetanus, rubeola, and rubella, or is in the process of being immunized. Kindergarten students must present proof of immunization against hepatitis B.

It is required that children entering kindergarten are immunized and have a medical assessment unless signed waivers are on file.

### Immunization Requirements

DPT	4 doses (if 4 <sup>th</sup> dose was given before the 4 <sup>th</sup> birthday, a 5 <sup>th</sup> dose is required)
OPV	4 doses (4 <sup>th</sup> dose must be given on or after the 4 <sup>th</sup> birthday)
MMR	2 doses (1 <sup>st</sup> dose on or after the 1 <sup>st</sup> birthday and the 2 <sup>nd</sup> dose at least 28 days later)
Hepatitis B	3 doses (2 <sup>nd</sup> dose at least 28 days after the 1 <sup>st</sup> dose, the 3 <sup>rd</sup> dose at least two months after the 2 <sup>nd</sup> dose, and at least 24 weeks old)
Chicken Pox	2 doses (1 <sup>st</sup> dose on or after the 1 <sup>st</sup> birthday and the 2 <sup>nd</sup> dose at least 3 months later). The date of the natural disease is acceptable. If child had chicken pox, parents must sign waiver.
Pevnar	As prescribed by the physician

# School Health Record

Child's Name:

Birthdate:

Name of School:

## Parent's Report

Please list diseases and other serious illness, injuries, or health conditions (including vision and hearing problems) your child has had:


## Immunization Record

Parents may waive the requirement for immunizations by signing a waiver.

Type of Immunization & Date (mo/day/yr)

DPT/DT*					
Polio*					
MMR*					
Hepatitis B*					
Chicken Pox*					
HIB					
Prevnar					

\*Required Immunizations (fill in all dates)

Comments:

Signature of Examining Physician:

Date: