2020-2021 ENROLLMENT CHECKLIST

Student Name: __________________________________________________________________________

Open Enrollment for the 2020-2021 school year is January 7, 2020 through April 1, 2020. The following documents must be provided to complete your student's enrollment application in order to reserve their seat:

- **GALA Student Enrollment Packet**
- **Birth Certificate or Passport**
- **Current Proof of Residency**
  - Copy of your current lease/lease receipt **OR** mortgage statement/property deed/property tax bill.
  - Utility bill/statement (water, gas, electric dated within the last 30 days) with the parent/guardian’s name and address.
- Individualized Education Plan (**IEP**) and Multi Factor Evaluation (**MFE**) (if applicable)
- **Proof of Custody** (if applicable) – Stamped certified copy of judgment or journey entry regarding custody or letters of guardianship from probate court.

**Some of these documents can be retrieved from the previous school. Please contact them to obtain these documents**

Please complete the following forms and return them to the school by the first day of school or your child will be unable to attend:
  - **Immunization/Shot Record** – Official copy from previous school or signed/stamped copy from physician

**Parent/Guardian is ultimately responsible for submitting all required documentation and that all forms are filled out completely. If there are any blank spaces, or missing required signatures or documents; the whole packet is invalid and may not be considered for enrollment processing. You may be required to submit further documentation at various times throughout the school year.**

*Your child must turn 5 years old by September 30th to be eligible for Kindergarten*

**GALA Contact Information:**
Call/Text: (216) 315-7942 or (216) 804-9178
Fax: (216) 274-9700
Email: info@GALACleveland.org
Visit: 13442 Lorain Avenue, Cleveland 44111
Learn more: [www.GALACleveland.org](http://www.GALACleveland.org)
1. **How do I submit my student’s enrollment application?**

   Completed applications and required documents can be returned by:

   **Email:** info@GALACleveland.org

   **Fax:** (216) 274-9700

   **Mail/Drop Off:**
   
   Global Ambassadors Language Academy
   
   13442 Lorain Avenue
   
   Cleveland, OH 44111

2. **Am I allowed to apply to both the Mandarin and Spanish programs at the same time?**

   If you are interested in either language program for your student(s), please write "1st Choice" and "2nd Choice" in the student application. Students can only enroll in one language program, and switching programs is not permitted.

3. **Does my child need to have language skills in Mandarin or Spanish to enroll?**

   No, our dual language immersion program does not require any prior language skills.

4. **Do I have to live in the city of Cleveland to attend GALA?**

   Anyone that resides in the state of Ohio are eligible to apply. GALA is tuition-free and public.

5. **When is my student enrollment application due?**

   Enrollment for the 2020-2021 school year is January 7, 2020 through April 1, 2020. Any applications received after 4:00 p.m. on April 1, 2020 will be enrolled on a first come first serve basis until spaces are filled and wait-listed by the date they are received. Enrollment for the 2020-2021 school year ends on January 11, 2021.

6. **All students who apply will be contacted within two weeks April 1, 2020 to notify them of their status.**

   If the school still has open positions after the lottery date has passed, then enrollment is conducted on a first come first served basis. Parents have **one week to accept or decline the spot. If no response is received after one week, your application will be removed from the enrollment list.**

7. **What is your lottery policy?**

   During open enrollment, if GALA receives more applications than there are seats available for any given grade level or program, we will hold a lottery as required by law, on April 1, 2020 at 5:00 p.m. The lottery will be conducted in the following manner:

   - Each applicant will be assigned a number;
   - The numbers will then be drawn at random by a disinterested third party;
   - The first number drawn will be the first new applicant placed in the available spaces in the given program and then the waiting list and so on until all numbers are drawn;
   - The School will separate the lottery and the waiting lists for each grade or age grouping;
   - Preference shall be given to students attending the school the previous year, to siblings of students attending the school the previous year, to students who reside in the district in which the school is located, and to students who are the children of full-time staff members employed at the school (provided the total number of students is less than 5% of the school’s total enrollment).

7. **How can I visit the school to learn more?**

   We encourage you to visit GALA for a tour of the school, meet the staff, and ask questions. Register to attend an Enrollment Information Session at: [www.GALACleveland.org/enrollment-information-session](http://www.GALACleveland.org/enrollment-information-session). Schedule a time to visit at: [http://www.GALACleveland.org/schedule-visit/](http://www.GALACleveland.org/schedule-visit/). Or contact us at (216) 804-9178 or [info@GALACleveland.org](mailto:info@GALACleveland.org).
Complete this application if you are a parent or legal guardian of the student(s) applying. Fill out one form per family and list each child.

GALA Student Enrollment Application

DATE: _________________________

PARENT/GUARDIAN INFORMATION

Relationship to Student(s) ___________ First Name ___________________ Last Name ___________________

Home Address __________________________ Apt./Unit/Suite ___________ City, ___________ ZIP Code ___________

Email Address (*please provide the best email to contact you at, this will be used for all school communications)

Mobile Phone Number __________________________ Home Phone Number __________________________

Work Phone Number __________________________ Additional Phone Number __________________________
(Please Specify Type)

How did you hear about GALA?

______________________________

STUDENT INFORMATION

First Name __________________________ Middle Name __________________________ Last Name __________________________

_____ / _____ / _______ Grade Applying To:

Birth Date ___K ___1 ___2 ___3 ___4 ___5

Program Language Interest: _______Spanish Immersion _______Mandarin Immersion
(*If you are interested in either language, write “1st choice” and “2nd choice”)

Current Grade __________________________ Current School. If none, write none.

Is your child currently expelled from his/her current school? Yes ______ No ______

Is your student Hispanic/Latino? ______ Yes ______ No ______

Race (choose one or more): ______American Indian or Alaskan Native ______Asian ______Black or African American

______Native Hawaiian or Pacific Islander ______White ______

The United States Department of Education has issued guidelines regarding the collection of data on race and ethnicity for public school students. The federal government requires all states to collect this information. If the above questions are not answered by the parent or guardian, the District Enrollment Officer will use observation identification to determine the student’s designation. The determination will be reported to the parent or guardian.
ADDITIONAL STUDENT INFORMATION

First Name ____________________________  Middle Name ____________________________  Last Name ____________________________  

/  /  

Birth Date 

Grade Applying To: 

K  1  2  3  4  5  

Program Language Interest: 

Spanish Immersion  Mandarin Immersion  

("If you are interested in either language, write "1st choice" and "2nd choice")  

Current Grade ____________________________  Current School. If none, write none. 

Is your child currently expelled from his/her current school?  Yes  No  

Is your student Hispanic/Latino?  Yes  No  

Race (choose one or more):  American Indian or Alaskan Native  Asian  Black or African American  

Native Hawaiian or Pacific Islander  White  

The United States Department of Education has issued guidelines regarding the collection of data on race and ethnicity for public school students. The federal government requires all states to collect this information. If the above questions are not answered by the parent or guardian, the District Enrollment Officer will use observation identification to determine the student's designation. The determination will be reported to the parent or guardian. 

Please initial each of the statements below expressing your understanding and agreement:  

_____ GALA's school model is most effective when students are in school, on time, every day.  

_____ GALA's school model is most effective when parent(s) or legal guardian(s) are engaged. GALA will expect families to make a minimum 10 hours per school year family participation commitment. (i.e. Parent-teacher conferences, school events, award ceremonies, community events, volunteering at the school, etc.)

_____ I understand that this application is the first step towards enrollment at GALA, but does not guarantee admission. If more applications are received than there are seats available, a lottery will be held. 

__________________________  ____________________________  

Parent Signature  Date 

Questions and/or Comments:  ___________________________________________________  

GALA recruits and admits students of any race, religion, national or ethnic origin, disability sex, or sexual orientation and affords them all of the rights, privileges, programs, and activities generally accorded or made available to our students. GALA does not discriminate on the basis of race, religion, national and ethnic origin, or sexual orientation in the administration of its educational policies, admissions policies, educational programs and/or extracurricular activities. GALA will not discriminate on the basis of race, color, or ethnic origin in the hiring of its certified or non-certified personnel. 

GALA is a community school established under chapter 3314 of the Ohio Revised Code. The school is a public school and students enrolled in and attending the School are required to take the proficiency tests and other examinations prescribed by law. In addition, there may be other requirements for students at the school that are prescribed by law. Students who have been excused from the compulsory attendance law for the purpose of home education as defined by the Administrative Code shall no longer be excused for that purpose upon their enrollment in a community school. For more information about this matter, contact the School administration of the Ohio Department of Education. ORC 3314.41
Appendix A: Language Usage Survey

Parents and Guardians: Please only complete this page of the survey. The back of this form will be completed by the school. A completed language usage survey is required for all students upon enrollment in Ohio schools. This information will tell school staff if they need to check your child’s proficiency in English. Answers to these questions ensure your child receives the education services to succeed in school. The information is not used to identify immigration status.

<table>
<thead>
<tr>
<th>Student Name: (First Name and Last Name)</th>
<th>Student Date of Birth: (mm/dd/yyyy)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Communication Preferences</strong></td>
<td></td>
</tr>
<tr>
<td>Indicate your language preference so we can provide an interpreter or translated documents at no cost when you need them. All parents have the right to information about their child’s education in a language they understand.</td>
<td></td>
</tr>
<tr>
<td>1. In what language(s) would your family prefer to communicate with the school?</td>
<td></td>
</tr>
<tr>
<td><strong>Language Background</strong></td>
<td></td>
</tr>
<tr>
<td>Information about your child’s language background helps us identify students who qualify for support to develop the language skills necessary for success in school. Testing may be necessary to determine if language supports are needed.</td>
<td></td>
</tr>
<tr>
<td>2. What language did your child learn first?</td>
<td></td>
</tr>
<tr>
<td>3. What language does your child use the most at home?</td>
<td></td>
</tr>
<tr>
<td>4. What languages are used in your home?</td>
<td></td>
</tr>
<tr>
<td><strong>Prior Education</strong></td>
<td></td>
</tr>
<tr>
<td>Responses about your child’s birth country and previous education give us information about the knowledge and skills your child is bringing to school and may enable the school to receive additional funding to support your child.</td>
<td></td>
</tr>
<tr>
<td>5. In what country was your child born?</td>
<td></td>
</tr>
<tr>
<td>6. Has your child ever received formal education outside of the United States? □ Yes □ No</td>
<td></td>
</tr>
<tr>
<td>If yes, how many years/months?</td>
<td></td>
</tr>
<tr>
<td>If yes, what was the language of instruction?</td>
<td></td>
</tr>
<tr>
<td>7. Has your child attended school in the United States? □ Yes □ No</td>
<td></td>
</tr>
<tr>
<td>If yes, when did your child first attend a school in the United States?</td>
<td></td>
</tr>
<tr>
<td><strong><strong><strong>/</strong></strong></strong>/______</td>
<td></td>
</tr>
<tr>
<td><strong>Additional Information</strong></td>
<td></td>
</tr>
<tr>
<td>Please share additional information to help us understand your child’s language experiences and educational background.</td>
<td></td>
</tr>
<tr>
<td>Parent/Guardian First Name: ___________________________</td>
<td>Parent/Guardian Last Name: ___________________________</td>
</tr>
<tr>
<td>Parent/Guardian Signature: ___________________________</td>
<td>Today’s Date: (mm/dd/yyyy) ___________________________</td>
</tr>
</tbody>
</table>

Thank you for providing the information above. Contact your school or district office if you have questions about this form or about services available at your child’s school. Translated information about schools’ civil rights obligations to English learner students and limited English proficient parents can be found here: [https://www2.ed.gov/about/offices/list/ocr/ellresources.html](https://www2.ed.gov/about/offices/list/ocr/ellresources.html)
MEDIA RELEASE

I, ____________________________________________, parent(s) or legal guardian(s) of ________________________________________________, a student at GALA ("the School"),

______ Consent (YES)  
______ Do not consent (NO)

to the use of my son/daughter/ward’s picture or likeness recorded on videotape, film, audio tape, paper, digital medium, or otherwise by the School, its agents, servants, or employees for any proper and legitimate educational, commercial, artistic, or marketing purpose and acknowledge the School’s ownership of any such recording.

Parent/Guardian Signature __________________________________ Date: _____________
Parent/Guardian Signature __________________________________ Date: _____________
ALLERGY NOTIFICATION

Student Name: ___________________________________________ Date: ____________________

☐ My child does not have any allergies. Parent/Guardian Initials: ____________________

List Allergies:

<table>
<thead>
<tr>
<th>Allergy</th>
<th>Reaction</th>
<th>Life Threatening</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td></td>
<td></td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td></td>
<td></td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td></td>
<td></td>
<td>☐ Yes ☐ No</td>
</tr>
</tbody>
</table>

Does your child require an EpiPen (epinephrine)? ☐ Yes ☐ No
If yes, please explain: __________________________________________________________________________
______________________________________________________________________________________________

Explain action to be taken for life threatening allergies: _____________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________

List medication to be taken for allergies: _________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________

Medications: If any medication needs to be administered in school, a physician must complete a separate School Medication Authorization Form available at the school.

I consulted with the school to make an Allergy Action Plan (if applicable) and have trained my child as to his/her needs and safety. We will review the monthly lunch menu together and discuss the vigilance required to self-monitor food products brought for potlucks or classroom celebrations and foods served on school-sponsored trips.

☐ I do ☐ I do not give consent for the School to notify others of my child’s allergy.

Parent/Guardian Signature __________________________ Date ____________
EMERGENCY MEDICAL AUTHORIZATION

School ___________________________ Student Name ___________________________

Address ___________________________ Tel ___________________________

Residential Parent or Guardian
Mother living with family? ☐ Yes ☐ No
Mother ___________________________ Address ___________________________
Tel ___________________________ Daytime Tel ___________________________
Father ___________________________ Daytime Tel ___________________________
Other Name ___________________________ Daytime Tel ___________________________
Relative or Childcare Provider ___________________________ Tel ___________________________
Address ___________________________ Relationship ___________________________

PURPOSE - To enable parents to authorize the emergency treatment for children who become ill or injured while under school authority when parents cannot be reached.

PART I OR PART II MUST BE COMPLETED

PART I (TO GRANT CONSENT)

I hereby give consent for the following medical care providers and local hospital to be called:

Doctor ___________________________ Tel ___________________________
Dentist ___________________________ Tel ___________________________
Medical Specialist ___________________________ Tel ___________________________
Local Hospital ___________________________ Tel ___________________________

In the event reasonable attempts to contact me at ___________________________ (tel #) or ___________________________ (other parent) at ___________________________ (tel #) have been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by Dr. ___________________________ (preferred doctor) or Dr. ___________________________ (preferred dentist), or in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to ___________________________ (preferred hospital) or any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of 2 other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained before the surgery is performed.

Facts concerning the child’s medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted:

__________________________________________

Date ___________________________ Signature of Parent ___________________________ Address ___________________________

DO NOT COMPLETE PART II IF YOU HAVE COMPLETED PART I

PART II (REFUSAL OF CONSENT)

I DO NOT GIVE MY CONSENT for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take no action or to:

__________________________________________

Date ___________________________ Signature of Parent ___________________________ Address ___________________________

School Entry Forms
Page 1 – 9/15/2006
Proprietary information of PSI Affiliates, Inc. May not be copied without consent.
# Emergency Contact and Medical Information for a Child

<table>
<thead>
<tr>
<th>Child's Name</th>
<th>Date of Birth</th>
<th>Sex</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent's/Guardian's Name</td>
<td>Parent's/Guardian's Name</td>
<td></td>
</tr>
<tr>
<td>Home Phone</td>
<td>Work Phone</td>
<td>Home Phone</td>
</tr>
<tr>
<td>Address</td>
<td></td>
<td>Address</td>
</tr>
<tr>
<td>City, ST ZIP Code</td>
<td></td>
<td>City, ST ZIP Code</td>
</tr>
</tbody>
</table>

## Alternative Emergency Contacts

<table>
<thead>
<tr>
<th>Primary Emergency Contact</th>
<th>Secondary Emergency Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Phone</td>
<td>Work Phone</td>
</tr>
<tr>
<td>Address</td>
<td>Address</td>
</tr>
<tr>
<td>City, ST ZIP Code</td>
<td>City, ST ZIP Code</td>
</tr>
</tbody>
</table>

## Medical Information

<table>
<thead>
<tr>
<th>Hospital/Clinic Preference</th>
<th>Physician’s Name</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insurance Company</td>
<td></td>
<td>Policy Number</td>
</tr>
</tbody>
</table>

**Allergies/Special Health Considerations**

I authorize all medical and surgical treatment, X-ray, laboratory, anesthesia, and other medical and/or hospital procedures as may be performed or prescribed by the attending physician and/or paramedics for my child and waive my right to informed consent of treatment. This waiver applies only in the event that neither parent/guardian can be reached in the case of an emergency.

<table>
<thead>
<tr>
<th>Parent's/Guardian's Signature</th>
<th>Date</th>
</tr>
</thead>
</table>

I give permission for my child to go on field trips. I release [Organization] and individuals from liability in case of accident during activities related to [Organization], as long as normal safety procedures have been taken.

<table>
<thead>
<tr>
<th>Parent's/Guardian's Signature</th>
<th>Date</th>
</tr>
</thead>
</table>

**Witness Signature**

<table>
<thead>
<tr>
<th>Date</th>
</tr>
</thead>
</table>
Ohio Department of Health • School and Adolescent Health

Health History

Student’s name

Sex

Date of birth

[ ] Male

[ ] Female

Family Health History

Please list allergies, heart problems, diabetes, cancer or other serious health conditions.

Father

Mother

Brothers and Sisters

Birth and Developmental History

[ ] No unusual birth or developmental history

Did the mother have any unusual physical or emotional illness during this pregnancy? [ ] Yes [ ] No

Was infant born full term? [ ] Yes [ ] No

Did the infant have any sickness or problems? [ ] Yes [ ] No

Briefly explain illness or problems.

How does the child’s development compare to other children, such as his or her brothers/sisters or playmates?

[ ] About the same [ ] Delayed [ ] Advanced

Student Health Conditions

[ ] YES, my child receives regular medical/health care for the following conditions: [ ] NO medical conditions

[ ] Allergies

[ ] Asthma

[ ] ADD/ADHD

[ ] Autism

[ ] Behavior concerns

[ ] Birth/congenital malformations

[ ] Bone/muscle/joint problems

[ ] Blood problems

[ ] Bowel/bladder problems

[ ] Cancer

[ ] Cystic fibrosis

[ ] Diabetes

[ ] Depression

[ ] Ear problem/hearing difficulty

[ ] Emotional concerns

[ ] Headaches

[ ] Heart problems

[ ] Hemophilia

[ ] Juvenile arthritis

[ ] Lead poisoning

[ ] Migraines

[ ] Neuromuscular disorder

[ ] Seizure disorder

[ ] Sickle cell anemia

[ ] Skin conditions

[ ] Speech problems

[ ] Traumatic brain injury

[ ] Vision problems (glasses, contacts)

[ ] Other ________________________________

[ ] Other ________________________________

[ ] Other ________________________________

[ ] Other ________________________________

Please explain any conditions above or any reasons for hospitalizations.

______________________________

Please indicate any allergies your child may have.

<table>
<thead>
<tr>
<th>Allergy type</th>
<th>Reaction</th>
<th>School restrictions or recommended actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] Bee/Insect</td>
<td></td>
<td></td>
</tr>
<tr>
<td>[ ] Food</td>
<td></td>
<td></td>
</tr>
<tr>
<td>[ ] Medication</td>
<td></td>
<td></td>
</tr>
<tr>
<td>[ ] Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

HEA 4240 8/06

Page 14 of 15
**Health History** continued

Please list any prescription and over the counter medication that your child takes on a regular basis.

<table>
<thead>
<tr>
<th>Medication and dose</th>
<th>Time</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Do any health and/or medical conditions require school restrictions, modifications, and/or intervention?

- [ ] Yes  
- [ ] No  
If YES, please explain.

Does the student require any special procedures and/or treatments for their health condition(s)?

- [ ] Yes  
- [ ] No  
If YES, please explain.

Please indicate any other information about your child’s health or development that you think would be helpful for the school to know.

-  
-  
-  
-  

Form completed by  

Relationship to student  

Date / /
Allowable Drivers List

Child’s Name: _____________________ Parent/Guardian Name: _____________________

By signing this paper, you are indicating that the people below are allowed to pick up your children.

Name ___________________________ Relationship to Child _____________________

Phone number __________________________

Name ___________________________ Relationship to Child _____________________

Phone number __________________________

Name ___________________________ Relationship to Child _____________________

Phone number __________________________

Name ___________________________ Relationship to Child _____________________

Phone number __________________________

Name ___________________________ Relationship to Child _____________________

Phone number __________________________

Name ___________________________ Relationship to Child _____________________

Phone number __________________________

I give permission to the people mentioned above to pick up my child. I give the school permission to release my child to any of the above mentioned people. I understand that anyone who is not on this list will NOT be permitted to pick up my child unless I call the office and notify them ahead of time.

Signature: ___________________________ Date: ___________________________
OFFICIAL CONSENT FOR RELEASE OF RECORDS

Student Name: ___________________________ Birthdate: ________________ Grade: ____________

I hereby authorize: ____________________________

(Previous School District): if School or Preschool is private, please indicate name)

(Street Address)

(City, State, Zip Code)

Phone: ____________________________ Fax: ____________________________

We are requesting the following information/records for the above named student:

☐ All personally identifiable data on file.

☐ The following records only:

We, with the understanding that the district cannot assume responsibility for the confidentiality of educational information disclosed, I authorize you to release educational information regarding the student named above in the manner indicated.

_________________________________________ (Parent/Guardian)

_________________________________________ (Street Address)

_________________________________________ (Date)

_________________________________________ (City, State, Zip Code)

SCHOOL USE ONLY

PLEASE PROVIDE THE FOLLOWING INFORMATION AND INCLUDE A COPY OF THIS COMPLETED REQUEST FORM WITH RECORDS.

CBA Enrollment Date: ____________________________

Student SSID Number: ____________________________

Previous District/School IRN: ____________________________

Previous District/School Withdrawal Date: ____________________________

Records can be faxed to:
(216) 274-9700
Attn: Office Manager

Records can be mailed to:
GALA, 13442 Lorain Avenue
Cleveland, Ohio 44111
Attn: Office Manager

FOR OFFICE USE ONLY

<table>
<thead>
<tr>
<th>Records requested</th>
<th>Date</th>
<th>By</th>
<th>Fax</th>
<th>Mail</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st Request</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2nd Request</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3rd Request</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
School Health Examination Record – Health & Immunization History

PART I - TO BE COMPLETED BY PARENT / GUARDIAN

Child’s Name ________________________________
(Print) Last __________ First __________ Middle __________

A. ALLERGIES – PLEASE LIST AND DESCRIBE ALLERGIES OR REACTIONS TO:

Medicines/Drugs: __________________________________________________________

Foods/Plants/Animals/Other: ________________________________________________

Recommended treatment is allergy is severe: __________________________________

B. INJURIES AND ILLNESSES – PLEASE LIST ANY SEVER INJURIES OR ILLNESSES:

<table>
<thead>
<tr>
<th>Injury / Illness</th>
<th>Age of Child</th>
<th>Check if hospitalized</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
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<tr>
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<td></td>
</tr>
</tbody>
</table>

C. ADDITIONAL INFORMATION:

What medications are given daily? ____________________________________________

What medications are given frequently, not daily? ______________________________

This child is usually:  □ very active  □ normally active  □ rather inactive

Does any relative or anyone in the home have tuberculosis, diabetes or other serious illness? __________________

Is there anything about your child that the school/teacher needs to know to understand him/her better? _________

D. OTHER PERTINENT MEDICAL INFORMATION:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

E. SIGNATURE OF PARENT/GUARDIAN:

_________________________________________  ____________________________
Signature of Parent/Guardian          Date Signed
F. IMMUNIZATION RECORD: Minimum requirements are listed for each vaccine. Those marked with an (*) are required by the Ohio Department of Health; all others are recommended by the Centers for Disease Control and Prevention.

<table>
<thead>
<tr>
<th>VACCINES</th>
<th>DOSE 1</th>
<th>DOSE 2</th>
<th>DOSE 3</th>
<th>DOSE 4</th>
<th>DOSE 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diphtheria (DTaP), Tetanus (DT/Tdap/Td), Pertussis*</td>
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<tr>
<td>DTap (7th – 9th grade only) *</td>
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<tr>
<td>Hepatitis B (Hep B) *</td>
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<tr>
<td>Measles, Mumps, Rubella (MMR) *</td>
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<tr>
<td>Polio (IPV or OPV) *</td>
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<tr>
<td>Varicella (Chicken Pox) * [2 doses K-2; 1 dose 3 – 6]</td>
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<tr>
<td>Influenza</td>
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<td>Pneumococcal Conjugate (PCV)</td>
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<tr>
<td>Meningococcal</td>
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<tr>
<td>Hepatitis A</td>
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<tr>
<td>Haemophilus Influenza – type b (HIB, preschool only)</td>
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<tr>
<td>Human Papillomavirus (Gardasil)</td>
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</tbody>
</table>

Recommended Assessments/ Screenings:

Vision: o Yes o No Date: ____________

Hearing: o Yes o No Date: ____________

Dental: o Yes o No Date: ____________

Lead: o Yes o No Date: ____________

BMI: o Yes o No Date: ____________

Other: o Yes o No Date: ____________

I have examined this child and found that he/she is in suitable condition for participation in school. The child has had the age appropriate immunizations as recommended by the Ohio Department of Health. My office has entered the child’s immunization record as noted above or attached a printed record of the immunizations or found that this child should be exempt from immunizations for the following reasons:

List any limitations or health conditions for this child (including allergies, daily medication and dietary restrictions):

G. SIGNATURE OF PHYSICIAN/PHYSICIAN’S ASSISTANT/ADVANCED PRACTICE NURSE:

______________________________ Date of Examination ______________________

Printed Name ____________________________

Office Address ___________________________

City/State/Zip __________________________ Office Phone: ______________________