CRESTVIEW LOCAL SCHOOLS

531 East Tully Street, Convoy, Ohio 45832

Phone: (419) 749-9100

Fax: (419) 749-2195

CASEY DOWLER, Early Childhood Center Principal

dowler.casey@crestviewknights.com

ANNUAL DENTAL SCREENING FORM

THIS FORM MUST BE COMPLETED, SIGNED AND DATED BY A DENTIST

FORM MUST BE PROVIDED WITHIN 30 BUSINESS DAYS OF ENTRANCE INTO THE PRESCHOOL PROGRAM AND ANNUALLY THEREAFTER

CHILD'S NAME ______________________________ DATE OF BIRTH ____________

OPTION A: EXAM COMPLETED BY CHILD'S DENTIST

Date of Exam: ____________________

______________________________ ____________________

Dentist Name **Phone Number**

______________________________ ____________________

Signature of Examining Dentist **Date of Signature**

____

Dentist Street Address

____

City, State, Zip

OPTION B: DENTAL SCREENING NOT COMPLETED

Please mark the reason the screening was not completed:

____ **No Insurance coverage*** ____ **Religious Conviction**

____ **Other:** ______________________________

______________________________ ____________________

Parent Signature **Date**

*If you do not have dental insurance, we have options that may help you. We will contact you with information

CRESTVIEW EARLY CHILDHOOD CENTER

531 East Tully Street, Convoy, Ohio 45832

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Fax: (419) 749-2195

ANNUAL MEDICAL DIAGNOSTIC SCREENING FORM

THIS FORM MUST BE COMPLETED, SIGNED AND DATED BY A PHYSICIAN

FORM MUST BE PROVIDED WITHIN 30 BUSINESS DAYS OF ENTRANCE INTO THE PRESCHOOL PROGRAM AND ANNUALLY THEREAFTER

CHILD'S NAME ______________________________ DATE OF BIRTH ____________

Please list any limitations or health conditions (including allergies, medications, dietary restrictions):

____

____

This Child is free from apparent communicable disease and is in suitable condition to attend a preschool program based on his/her medical history and physical condition at the time of this examination.

______________________________ ______________

Signature of examining Health Professional **Date of Exam**

Circle one: Physician Physician's Assistant Advanced Practice Nurse

OfficeAddress:______________________________ Office Phone:____________

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Please Retain this Form Until All Results Are Obtained

Beginning July 1, 2007, the Ohio Department of Education requires all students enrolled in a state funded preschool program receive these screenings and documentation to be on file. This will be a one time only screening for each child.

CHILD'S NAME ______________________________ DATE OF BIRTH ____________

Assessments/ Screenings	Assessment/Screening Completed (circle one)	Date Completed	Reason Not Completed (health professionals decision, insurance coverage, religious conviction, other)
Lead	YES NO		
Hemoglobin*	YES NO		

*Physician Determined

Comments:

____

____

Physician's Signature: ______________________________ Date: ______________

Physician's Name: ______________________________________

Phone Number: ______________________________________

Address: ______________________________________

UPON RECEIVING THE RESULTS OF THIS REQUIRED BLOOD WORK,
PLEASE FAX OR MAIL THIS FORM TO:
Crestview Local Schools
531 E. Tully St.
Convoy, Ohio 45832
Fax: 419-749-2195
Attention: Casey Dowler- ECC Principal

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CHILD'S MEDICAL STATEMENT FOR ENROLLMENT

THIS FORM MUST BE PROVIDED BY THE FIRST DAY OF SCHOOL

CHILD'S NAME ______________________________________ DATE OF BIRTH __________

This form must be completed or a copy of immunization records can be provided.

This child has had the immunizations required by section 3313.671 of the Revised Code for admission to school, or has had the immunizations recommended by the Ohio State Department of Health for infants and toddlers or is to be exempted from these requirements for medical, philosophical, or religious reasons.

Immunizations (enter month, day and year) or attach a copy of immunization record:

VACCINE	DOSE 1	DOSE 2	DOSE 3	DOSE 4	DOSE 5
Hep A					
Hep B					
DtaP					
Influenza					
Polio					
Pneumococcal					
MMR					
HIB					
Varicella					
Rotavirus					

If separate, measels__________, mumps__________, rebella __________

______________________________________ ____________________

Physician's Name **Phone Number**

______________________________________ ____________________

Physician's Street Address **City, State, Zip**