Berea City School District
Immunizations & Physical Examination

Student Name	Male Female	Date of Birth:	School:

Immunizations (Must be excluded from school if information not provided or student not up-to date)

DPT1 or DT1:	**DPT2 or DT2:**	**DPT3 or DT3:**	**DPT4 or DT4:**	**DPT5 or DT5:**

OPV1 or IPV1 (circle one):	**OPV2 or IPV2 (circle one):**	**OPV3 or IPV3 (circle one):**	**OPV4 or IPV4 (circle one):**
HIB1	**HIB2**	**HIB3**	**HIB4**
MMR1:	**MMR2:**	**Chickenpox:**	**Chickenpox:**
HBV1	**HBV2**	**HBV3**	

DTP = Diphtheria/Pertussis/Tetanus		DT = Diptheria/Tetanus	***Immunizations Recorded By:***
HIB = Haemophilus B	HBV = Hepatitis B	MMR = Measles/Mumps/Rubella	
IPV = Inactivated Polio Vaccine		OPV = Oral Polio Vaccine	

History & Physical Examination

REQUIRED FOR PRESCHOOL *-- Due on admission to program & annually from date of examination.*

(Recommended for kindergarten students) (WNL = Within Normal Limits)

Examined:	WNL	Comments/Concerns:	Examined:	WNL	Comments/Concerns:
General Appearance			Pelvis		
Neurological			Genitalia Muscular-Skeletal		
Eyes					
Ears			Skin		
Nose			Height (actual)		
Throat (Tonsils)			Weight (actual)		
Mouth (Teeth)			Blood Pressure		
Neck			Posture, gait Growth & Development		
Heart					
Lungs					
Abdomen			Speech		

VISION--RIGHT EYE	VISION--LEFT EYE	HEARING--RIGHT EAR	HEARING--LEFT EAR
		1000 Hz (20 dB HL) Pass Fail	1000 Hz (20 dB HL) Pass Fail
20/	20/	2000 Hz (20 dB HL) Pass Fail	2000 Hz (20 dB HL) Pass Fail
Color: Pass Numbers	Pass Trails Fail	4000 Hz (20 dB HL) Pass Fail	4000 Hz (20 dB HL) Pass Fail

Labs and Results

Hematocrit _____% date _____	Lead _____mcg/dl date _____

Comments:					

Child is free from apparent communicable disease and is in suitable condition to attend a preschool program.

Date of Examination	Physician Signature	Printed/Stamped Name of Physician

Please return completed form to: School Office or Clinic

BCSD
Berea City School District

Berea City Schools Preschool Dental Assessment Form

Child's Name: _____ Date of Birth: _____

School: _____

Exam Completed by: ☐ DMD ☐ RDH ☐ Other (specify): _____

Provider Setting: ☐ Doctor/Dentist/Clinic ☐ School/Center ☐ Other (specify): _____

Evaluation Type: ☐ Screening ☐ Exam

TO BE COMPLETED BY PARENT

Flossing Frequency: ☐ Daily ☐ Weekly ☐ Occasionally ☐ Never

Number of Times per Day Child Brushes Teeth: _____

Uses Fluoride Toothpaste: ☐ Yes ☐ No Takes Fluoride Supplement: ☐ Yes ☐ No

Gum condition: ☐ Normal ☐ Swollen ☐ Bleeds Easily ☐ Infected

General Comments on Oral Health: _____

_____

If child is NOT being seen by dentist:

☐ I want my child to be seen by a dentist but need more information. *Danae Willenberg, Middleburg Hts 440-888-6300*

☐ I do NOT want my child to be seen by a dentist at this time.

Some Local Dentist Names:

Arlene Coloma, Strongsville 440-526-2350
Theresa M. Bonamer, Strongsville 440-572-5437
James L. Kozik, Metro Health 216-778-7800

Parent Signature: _____ Date: _____

Today's Visit:

☐ Visual Screening
☐ Full Exam
☐ X-Rays
☐ Cleaning
☐ Fluoride Treatment
☐ Oral Hygiene Instruction
☐ Treatment (specify)

_____
_____
_____
_____
_____

Treatment:

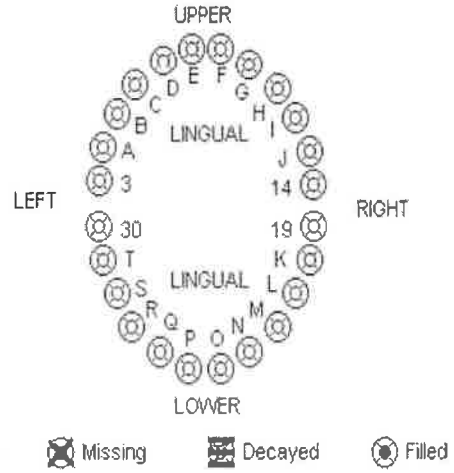
☐ No Needs
☐ Treatment Needed

Next Appointment:

_____/_____/_____

Treatment Plan:

_____
_____
_____
_____
_____



Dental Professional's Signature: _____ Examination Date: _____/_____/_____

Printed or Stamped Name: _____ Phone Number: _____

Address of Provider: _____

Revised 2/24/2020