Bethany School Admission and Authorization Forms

Please Complete **ALL** of the following forms and return them to the office
BY THE CHILD'S FIRST DAY OF SCHOOL

1. Student Permission Slip (below)
2. Consent for Records Release (students entering Grades 1 - 8)
3. Religious Information Form
4. Student Health History
5. Physical Examination: **To be completed by physician**
6. Immunization Report: **To be completed by physician**
7. Oral Assessment: **To be completed by the dentist**

** Birth Certificate: **Please provide a copy**

Bethany School
555 Albion Avenue
Cincinnati, OH 45246
(513) 771-7462
Fax (513) 771-2292

STUDENT PERMISSION SLIP

These agreements extend for the duration of _____'s
(full name of child)

enrollment at Bethany, unless denied or limited by me in writing to the school.

1. Bethany School has permission to take my child on picnics, outings, and field trips as a part of the scheduled extracurricular program of Bethany School. Transportation will be by parent car, a school vehicle (which is driven by a teacher who has been certified to do so), or a school bus hired by the school. This permission shall extend to athletic events and programs, theater and musical trips, trips to museums, parks, and other educational institutions.

_____ _____
(date) (Signature of Parent or Guardian)

Consent for Record Release
To be mailed to your child's current school
(for students entering grades 1 - 8)

This form gives my permission for BETHANY SCHOOL
to request my child's records from:
(please print)

(School)_____

(Address)_____

(City,State, Zip)_____

****

As Parent and/or Guardian of:

Name of Student _____

Date of Birth _____ Current Grade_____

I hereby authorize you to release all records, psychological evaluations, aptitude testing, academic testing, as well as intelligence testing, and health records to:

Mrs. Teri Mauntel, Admissions
Bethany School
555 Albion Avenue
Cincinnati, Ohio 45246
Fax: 513-771-2292

Signature of Parent:_____ Date:_____

Street: _____

City, State, Zip: _____

Grade_____

RELIGIOUS INFORMATION FORM

Please complete this form and return it to the office

1. Name of student_____
(Last Name) (First Name)

2. Religious affiliation of student's immediate family (circle all that apply)
If husband and wife hold different affiliations, circle both.

CHRISTIAN JEWISH HINDU MUSLIM BUDDHIST
OTHER_____ NONE

3. Is this student currently active in a religious congregation? yes _____
no_____

If Christian, please answer the following questions:

4. Denomination (please circle)

Baptist Presbyterian Non-denominational
Episcopalian Roman Catholic
Lutheran Methodist

Other _____

5. Has your child been baptized? Yes_____ No_____

6. Does your child presently receive Communion in your church? Yes____ No_____

7. Does this student wish to receive communion in Chapel at School? Yes____No_____

(All children come forward in Chapel to receive either a blessing or communion. Bethany School offers communion to all who are baptized and who receive communion in their own congregation. Children are instructed during Christian Education on communion, baptism, and how to receive communion. Any questions or concerns can be directed toward the Chaplain.)

Parent or Guardian Signature: _____ date: _____

STUDENT HEALTH HISTORY (TO BE COMPLETED BY PARENT)

STUDENT _____ **GRADE** _____ **HOMEROOM** _____

Sex: ___ Male ___Female **Date of birth** _____/_____/_____

Please complete this form and return it to school as soon as possible. If there are any future changes in your child's health status, please call Peggy Brockmeier, RN or send a note to school. **Check all health conditions your child may have.**

- ▫ **ADD / ADHD**
- ▫ **ALLERGIES** or reactions to: (Please explain)

Food(s) _____

Medication(s) _____

Plant / Animal / Environmental _____

_____

- ▫ **ASTHMA** (Identify triggers)

_____

Has your child ever needed emergency treatment for asthma?

___ YES ___ NO

- ▫ **BLADDER PROBLEMS** (Please explain)

_____

- ▫ **BOWEL PROBLEMS** (Please explain)

_____

- ▫ **DEVELOPMENTAL DELAY** (Please explain)

_____

- ▫ **DIABETES** Age of diagnosis _____
- ▫ **EAR INFECTIONS** (frequently after age of 3)

Approximate date or age of last infection _____

Currently under the care of ENT? ___ YES __ NO

Currently has PE tubes? ___ YES ___ NO

_____ Wears hearing aid in right/left ear (circle)

_____ Has hearing loss in right/left ear (circle)

- ▫ **EATING DISORDER**
- ▫ **EMOTIONAL/ BEHAVIORAL CONCERNS**
- ▫ **EYE PROBLEMS** (Please explain)

_____

Wears glasses/contacts? ___ YES ___ NO

___ wears all the time or ___ for reading ___ for distance

- ▫ **HEADACHES** (frequent)

Migraines? ___ YES ___NO

- ▫ **HEART CONDITION** (Please explain)

_____

- ▫ **KIDNEY DISEASE** (Please explain)

_____

- ▫ **PHYSICAL DISABILITY** (Please explain)

_____

_____

- ▫ **RECENT HOSPITALIZATION/SURGERY**

SIGNIFICANT INJURY (Please explain)

_____

- ▫ **SEIZURES / EPILEPSY**

Date of last episode _____

- ▫ **SPINAL CURVATURE (**scoliosis, etc.)
- ▫ **TICS / NERVOUS TWITCHES**

Has your child traveled outside the United States in the past year? _____ No _____ Yes _____ (Where?)

My child takes the following daily medication(s) _____

My child takes the following medication(s) occasionally _____

Please identify any other health information not listed above that you believe school personnel need to be aware of:_____

_____

List any health conditions that require school restrictions, modifications, and/or interventions: _____

_____

This information may be shared with school personnel if it is pertinent to health and safety, educational progress and/or behavioral management plan.

Parent/Guardian Signature_____ **Date** _____

Ohio Department of Health • School and Adolescent Health

Physical Examination

Student's name	Sex ☐ Male ☐ Female	Date of birth / /

Height	Weight	BMI percentile	BP

Screening Tests

Vision

Date performed / /

Distance Acuity	☐ R	☐ L
Muscle Balance	☐ Pass	☐ Fail
Stereopsis	☐ Pass	☐ Fail
Color	☐ Pass	☐ Fail
Child wears glasses?	☐ Yes	☐ No
Tested with glasses?	☐ Yes	☐ No
Referral made?	☐ Yes	☐ No

Hearing

Date performed / /

Pure Tone		
Right ear	☐ Pass	☐ Fail
Left ear	☐ Pass	☐ Fail
Child wears hearing aid?	☐ Yes	☐ No
Child under the care of a hearing specialist	☐ Yes	☐ No
Referral made?	☐ Yes	☐ No

Postural

Date performed / /

☐ No abnormality noted
☐ Screening not done
☐ Referral made
Comments
_____
_____
_____

Speech/Language

Speech assessment completed	☐ Yes	☐ No
Child has no discernible speech problem	☐ Yes	☐ No
Speech evaluation recommended	☐ Yes	☐ No

Child has possible problem with _____

Lead Poisoning

☐ Date _____ Type ☐ C ☐ V Results_____ µg/dL
☐ Date _____ Type ☐ C ☐ V Results_____ µg/dL

Tuberculin Test

Date_____ Type _____ Results_____

Health History (Serious or chronic illnesses/injuries/surgeries)

_____

Physical Examination Date of most recent examination / /

☐ Essentially normal ☐ Abnormalities as follows

_____
_____

Is this child able to participate fully in:

Classroom and academic activities	☐ Yes	☐ No	Physical education classes	☐ Yes	☐ No
Competition athletics	☐ Yes	☐ No	Contact and collision sports	☐ Yes	☐ No

If limitations are advised, please specify

_____
_____

Does this child have any physical, developmental or behavioral issues that may affect his/her educational process?

_____
_____

HealthCare Provider's signature	Print name	Phone ( )
Address		Date / /
City	State	ZIP

HEA 4242 8/06

Ohio Department of Health • School and Adolescent Health

Immunization Report

Student's name	Sex	Date of birth
	☐ Male ☐ Female	/ /

Students are required to be immunized in accordance with Ohio law (Ohio Revised Code 3313.67/3313.671).
A copy of the child's immunization record may be attached or dates may be entered below.
Please note the month, day, and year for each immunization should be on record.

Vaccine	**Record complete dates** (month, day, year) **of vaccine doses given**					
Diphtheria, Tetanus, Pertussis (DTP)						
DTaP, Tdap						
DT, Td						
Polio						
Hepatitis B (HBV)						
Measles, Mumps, Rubella (MMR)						
Varicella (Chickenpox)						
Hepatitis A						
Meningococcal (MCV4, MPSV4)						
Pneumococcal (PCV)						
Measles (Rubeola) only						
Rubella only						
Mumps only						
Haemophilus influenza Type b (Hib)						
Influenza						
Other						

This information was provided by ☐ Health Care Provider ☐ Parent/Guardian ☐ Other _____

Signature	Print name	Date
		/ /

HEA 4241 8/06

Ohio Department of Health • School and Adolescent Health

Oral Assessment

Student's name	Date of birth
	/ /

The following services have been performed (please check all that apply)

☐ Examination ☐ Fluoride application ☐ Oral prophylaxis (cleaning) ☐ Prescription for fluoride supplement
☐ Orthodontic assessment ☐ Radiographs ☐ Dental sealant ☐ Treatment (restoration, pulp therapy)
☐ Other_____

The following oral hygiene instruction was provided (please check all that apply)

☐ Toothbrushing ☐ Flossing ☐ Dietary counseling ☐ Use of fluoride mouthrinse
☐ Other_____

The following statements are applicable (please check all that apply)

☐ All necessary preventive services have been performed. (Fluoride treatment, prophylaxis)
☐ No restorative services are required at this time.
☐ Further treatment is indicated.(See comments)
☐ Further appointments have been arranged. (Orthodontic, restorative)
☐ Routine recall visits recommended.

Comments

_____

_____

_____

_____

Dentist's signature	Print name	Phone ( )
Address		Date / /
City	State	ZIP