

Badin High School

571 New London Road, Hamilton, Ohio 45013

513-863-3993 / Fax 513-785-2844

<http://www.badinhs.org>

SCHOOL HEALTH SERVICES

May, 2008

Dear Parent/Guardian of Upcoming Sophomore Students:

In an effort to keep our adolescent students healthy and to reduce the risk of illness, we are recommending that you take your son/daughter for a health care visit to your physician or other health care provider, in their sophomore year. We are targeting all 10th grade students, so that their health care status might be evaluated, that they receive their "catch up" adolescent immunizations, and that your son/daughter be offered preventive services, if necessary. The value of preventative health care services to teens cannot be over-emphasized. Purposes of the health care visit for your teen might include the following immunization:

- Varicella vaccine (chicken pox)
 - Hepatitis B vaccine (series of 3 shots)
 - Td (tetanus-diphtheria) due every 10 years
- ** See attachment **

These routine adolescent immunizations are recommended by the American Medical Association (AMA) and the American Academy of Pediatrics (AAP). This visit to your adolescent's health care provider offers both you and your teen an opportunity to discuss adolescent concerns such as alcohol and tobacco use, dietary behaviors, physical activity and other high risk health behaviors. As a parent of an adolescent, you too, may have questions for your teen's physician about specific adolescent issues.

Enclosed are two copies of physical exam (OHSAA and Badin's) forms which should be filled out by your physician and then returned by the student to the school health office no later than October 30th. Regular dental examinations are also encouraged, and the dental form that should be completed by your dentist is provided in this packet.

WHEN THIS MEDICAL EXAM FORM IS COMPLETED BY YOUR DOCTOR, IT MAY BE USED DURING THE ENTIRE SCHOOL YEAR SHOULD YOUR SON/DAUGHTER BE PARTICIPATING IN ANY ACTIVITY WHICH REQUIRES A PHYSICAL EXAM. FEEL FREE TO CONTACT THE SCHOOL NURSE FOR A COPY OF THIS FORM SHOULD YOUR SON/DAUGHTER NEED A COPY. THE OHIO HIGH SCHOOL ATHLETIC ASSOCIATION REQUIRES A PREPARTICIPATION PHYSICAL EXAMINATION FORM TO BE FILLED OUT BY THE PARENT. THIS IS MANDATORY FOR YOUR SON/DAUGHTER TO HAVE IN ORDER TO PARTICIPATE IN ANY SPORT. THIS FORM IS ENCLOSED IN THE PACKET.

I will accept the athletic physical form as your son/daughter's physical but a copy of it must be on file with his/her coach as well.

Thank you for your support and cooperation in this very important health matter.

Sincerely, 
Amy Bonham, RN, BSN
School Nurse

Attachments: Adolescent Information Sheet/this letter
Medical Exam Form
Dental Exam Form

FORMS SHOULD BE RETURNED TO THE SCHOOL HEALTH OFFICE BY OCTOBER 30th, 2008.

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(513) 863-3993/FAX (513) 785-2844
E-Mail: abonham@mail.badinhs.org

DENTAL EXAMINATION REPORT

GRADE _____ **HOMEROOM** _____

Name _____ Date _____ District _____

Address _____ Phone _____

Date Seen By Dentist _____ Date Returned _____

Has your child had a dental examination by your family dentist within the last six months? If not will you arrange for such an examination as soon as possible?

In either case, please have the dentist fill in and sign below, then return this form to the school..

This is to certify that I have examined and found the condition checked below:

_____ No dental defects. _____ Treatment has been started.

_____ Dental defects which were present
have been completely cared for. _____ Treatment is needed but no
provision is made for it.

DATE _____ SIGNATURE OF DENTIST _____

It is not possible to take my child to the family dentist for examination or treatment. _____

DATE _____ SIGNATURE OF PARENT/GUARDIAN _____

PLEASE RETURN TO HEALTH CLINIC BY OCTOBER 30th, 2008.

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MEDICAL EXAMINATION REPORT BY PHYSICIAN

GRADE _____

Student's Name _____ Sex _____ Date of Birth _____
 Height _____ Weight _____ Blood Pressure _____ Skin _____
 Head (size, shape, symmetry) _____ Eyes (right) _____ (left) _____
 Vision (right) _____ (left) _____ Ears (R) _____ (L) _____ Hearing (R) _____ (L) _____
 Nose _____ Throat _____
 Neck (lymph nodes and thyroid) _____ Chest _____
 Heart _____ Lungs _____ Abdomen (hernia) _____
 Genitalia _____ 16. Neurological _____
 Posture & Extremities (including skeletal abnormalities) _____
 Neurological _____ Speech Difficulty _____
 Is this student capable of carrying a full program of schoolwork including gymnastics and athletics? Yes _____ No _____

Recommended Restrictions _____

General appearance, nutritional state, vitality _____

Is this student on any daily medication? _____

If so, what is the medicine? _____

** Any medical, psychological or emotional provision which health services should be aware. If so, please identify below;

Disease	1 st Date	2 nd Date	3 rd Date	4 th Date	5 th Date
DTaP/DTP/DT					
Polio					
Rubella(German measles)					
Mumps					
Rubeola (reg measles)					
Varicella					
Hepatitis B					
TB Skin Test					
Hib(Preschool) Haemophilus Influenza Type B					

PHYSICIAN'S NAME _____ PRINTED _____ PHYSICIAN'S SIGNATURE _____ DATE _____
 PHYSICIAN'S PHONE () _____