



Marion County Schools

Dental Examination and Health Check Requirements for Pre-K, Kindergarten, 2nd, 7th & 12th Grades



****Important information****

WVBE Policy 2423-Health Promotion and Disease Prevention requires students entering Pre-K, Kindergarten, 2nd, 7th and 12th grades to show proof of a dental examination and Health Check examination AND proof of required immunizations prior to entry into school in the fall.

WVBE Policy 2422.7-10.1.g – requires any student who has Emergency Medications ordered must have the medication administration form AND the medication available at school or the student may not attend school.

Students may NOT attend school OR participate in extra-curricular events (including practices, games, or performances) without proof of required immunizations.

If your child has already received their health and dental examination within the last 12 months, please ask your child’s physician and dentist to complete this form, sign and date to show proof of the exams. If your child’s physician provides an alternate form, it is accepted with provider signature. (For the exams to be considered up to date, the forms should be dated within one year of the first day of school).

Student Name: _____

School: _____

Date of Birth: _____

IMMUNIZATIONS - **STUDENT MAY NOT ATTEND SCHOOL WITHOUT PROOF OF IMMUNIZATIONS**

Record of Tdap: _____ *(Required for 7th & 12th grade entry)*
(date)

Record of MCV: _____ *(Required for 7th & 12th grade entry)*
(date) (date)

Record of HPV: _____ *(Optional, but recommended)*
(date) (date) (date)

Provider’s signature: _____

HEALTH EXAM

Date of exam: _____ Provider’s signature: _____

Allergies: _____

Current medication(s): _____

Is this medication required at school? Yes: _____ No: _____

Is this an Emergency/Rescue medication? Yes: _____ No: _____

Health conditions that may require care at school: _____

Developmental Screen: WNL: _____ **OR** Abnormal (explain): _____

Height: _____ Weight: _____

Vision: Pass _____ Fail _____ Hearing: Pass _____ Fail _____

DENTAL EXAM

Date of exam: _____ Provider’s signature: _____

Please return this form to your child’s school
Attention: School Nurse
-OR-
(Fax) 304-367-8976