Allen County Non-Public School Association

Kindergarten Health Forms 2017-2018

Contents:

All forms are required and should be returned to the school office no later than the first day of school.

***The only exception is the medication consent and that should be returned only if medication is required for school day use**

Important Information for Kindergarten Entrance

Packet

This packet includes several important forms that you will need to complete and return to the school office before your kindergartener begins their first day of school.

About Immunizations:

IC 20-34-4-2 requires that all students entering Kindergarten be fully immunized following the ACIP (Advisory Committee on Immunization Practices) and Indiana State Department of Health guidelines. These mandatory vaccinations include DTaP (5), IPV (4), Hepatitis B (3), MMR (2), Varicella (2) and Hepatitis A (2). These minimum doses must be met and they must have been given at the proper minimum age and have the proper intervals between each one to be acceptable for the state school requirements. A photocopied record of your child's immunizations from your child's physician must be provided to the school **BEFORE THE FIRST DAY OF SCHOOL** as proof of the vaccines having been given. Students who will not be receiving immunizations for religious reasons (IC 20-34-3-2), or those who have a medical contraindication(IC 20-34-3-3) to vaccine administration, must have the appropriate exemption forms filed annually with the school office (contact the school office to obtain the correct form).

It is important that you review your child's immunization records now and obtain these necessary immunizations from your child's physician, the Fort Wayne Allen County Department of Health, or any Super Shot location. Remember to provide the school with documentation of all shots received from infancy through the current date.

Required FREE vision MCT Exam for all kindergarteners:

IC 20-34-3-12 requires all kindergarten or first grade students to have an MCT vision exam done by either an optometrist or ophthalmologist.

We have chosen kindergarten to be done. **To take advantage of a FREE vision screening for your child, please check the back side of the "Kindergarten Vision Examination" form for a list of local optometrists who have agreed to provide this service at no cost for your kindergarten child.**

If you prefer to use your own optometrist or ophthalmologist, please take this form to their office and have them completely fill out after your child's exam. Please understand that if you choose your own, you may have an additional cost to incur. It is important that your child be screened for any vision problems at an early age to detect and correct any abnormalities that may exist. Having an eye professional perform this exam is vital.

This exam needs to be done before the first day of school.

About washing hands:

Now is the time to teach your child the importance of good hand washing. Keeping hands clean is one of the best ways to prevent the spread of infection and illness. Help your child stay healthy by encouraging good hand washing habits.

Regular sleep is very important:

Regular sleep habits are very important to the health and well- being of your child. A young child needs, on average, 10-12 hours of sleep a night. Establish a regular bedtime. Turn off the TV and videos and read a book before bed!

If you have any questions, please contact the school nurse.

PLEASE RETURN ALL PAPERWORK TO THE SCHOOL OFFICE AS SOON AS IT IS COMPLETED.

General Health Information

Physicals/Health Questionnaire: All students new to our school are required to have a recent physical signed by their physician along with the "Health Questionnaire" form **submitted to the school office no later than the first day of school**.

Dental: All students are strongly encouraged to visit their dentist regularly and have the "Certificate of Dental Examination" form completed prior to their first day of school. While we do not screen for dental issues, it is an important part of our general health and well being.

Immunizations: IC 20-34-4-2 requires that **ALL** students have the required immunizations **PRIOR** to, **and on file with, the school before the first day of school**. These immunizations need to be given according to the ACIP (Advisory Committee on Immunization Practices) and the Indiana State Department of Health, this includes proper intervals between each required dose. **Unfortunately, if this is not done, you will receive a letter excluding your child from school until the immunizations have been obtained and proper paperwork has been filed.**
The only exception to this rule is a signed "Medical Exemption" form filled out by your child's physician (IC 20-34-3-3), or a "Religious Objection" form signed by the parents/legal guardians (IC 20-34-3-2). Please contact the nurse if you need either of these forms.

CHIRP: As required by IC 20-34-4-6, we report immunizations to the State Department of Health each year on all students in **grades K, 1 and 6**. This report is currently done online through CHIRP (Children and Hoosier Immunization Registry Program) and we will need a consent signed for each child in order to report this information to the state. If you have children in grades K, 1 or 6, a form will be made available to you for your signature. **This form needs to be submitted to the school office no later than the first day of school.**

When your child is ill: Children with fever, diarrhea, vomiting or other symptoms of illness should stay at home, and, if indicated, be evaluated by the doctor for diagnosis and appropriate treatment. Any fever of **99.9** degrees or above means that your child **must stay home for at least 24 hours** (free of fever **and** without the use of acetaminophen or ibuprofen). This means that if your child was sent home from school the day before with a fever, they need to wait **at least** 24 hours before they will be admitted back to school.

Medications: We will only administer FDA approved over–the–counter (OTC) and prescription medications prescribed to your child (this does not include any herbal medications). These medications need to be brought to school by an adult in their original package and accompanied by the medication consent form found on our website or in the school office. Medication brought in to school will only be available during school hours. Our school policies are in accordance with IC 20-34-3-18. All medication will be kept in a locked cabinet with the nurse, or trained staff member dispensing according to the package instructions. Students are not to have medication with them at any time. The only exception to this is if your child needs emergency medication (ex. insulin, an inhaler or an epinephrine injection) and the proper paperwork is filled out and on file with the school. (Forms may be found in the school office) If needed, this form requires a signature from your child's physician and is only for their EMERGENCY medication. These policies are in place to keep your child and others in the building as safe as they can be during the school day. A reminder that all cough drops are considered OTC medication and need to be kept in the school office for your child's use. Please read our full medication policy on the reverse side of the "Medication Consent" form.

Please understand that NO medication can be sent home with your child.

Health Screening Information

During the school year, the following health screenings will take place as part of the health services to your child, and fulfillment of the health screening laws of the State of Indiana. Some students will receive referral letters from the school nurse as the result of these screenings.

HEARING SCREENING

Hearing screenings will be conducted according to IC 20-34-3-14, on all students in grades **1-4-7, and 10** as mandated by the state. We will also check all students new to the school, and any others by special request. The school nurse, or trained volunteers, will conduct this screening. Re-checks will be done at least 2 weeks later on students who have questionable results and referral letters will be sent to those who do not meet the required thresholds on these rechecks. The school nurse will also notify the teachers of those students that referral letters are sent to.

PLEASE COMPLETE AND RETURN ALL REFERRAL FORMS TO THE ATTENTION OF THE SCHOOL NURSE.

VISION SCREENING

Both far and near vision screening will be conducted according to IC 20-31-3-12 for all students in grades **3-5-8**. We will also check all students by special request. The school nurse, or trained volunteers, will conduct this screening. This Indiana Law also requires that **either K or grade 1** be examined by an eye professional, so we have decided to send all of our kindergarten students for the FREE exam that local eye Dr's have offered to us. Re-checks will be done on students who have questionable results and referral letters will be sent to those who do not meet the minimum requirements on these rechecks. The school nurse will also notify the teachers of those students that referral letters are sent to.

PLEASE COMPLETE AND RETURN ALL REFERRAL FORMS TO THE ATTENTION OF THE SCHOOL NURSE.

(reviewed ACNPSA 1/17)

Allen County Non-Public School Association

HEALTH QUESTIONNAIRE

(Parent/Guardian needs to complete)

Please Print

Student_____Grade_____Date of Birth___/___/___

Address_____

Phone Number_____

Father's name_____Mother's name_____

Student lives with_____

Health History

Check all that apply to your child

____ADD/ADHD (circle)	____Emotional Disorder	____Scarlet Fever
____Allergy (specify)	____GI/GU Issues ☐	____Seizures
Seasonal _____	____Hearing Impairment ☐	____Tuberculosis
Food _____	____Hepatitis	____Vision Impairment
Other _____	____Measles/Mumps/Rubella	____Whooping Cough
____Asthma	____Mononucleosis	____Other_____
____Chickenpox ☐	____Physical Handicaps ☐	____Other_____
____Diabetes ☐	____Pneumonia	____Other_____
____Chronic Ear Infections ☐	____Rheumatic Fever ☐	____Other_____

Any checks made above, please give explanations and dates of diagnosis:

_____

_____

Has your child had an infectious/communicable disease other than those listed above? Please explain, giving relevant dates:

_____

_____

Does your child require the use of an EPI-PEN for allergic reactions?_____

CONTINUED ON REVERSE

Please be specific and include the month/year:

Severe Illnesses: _____

Severe Injuries: (head injury, fractures, etc.): _____

Diagnostic Procedures: _____

Hospitalizations: _____

Surgical Procedures: _____

Is there any other information about your child's health status that you think the school should know which may be relevant to your child's health and safety or the health and safety of others in the school environment?

_____

_____

_____

Please list any condition that should be considered in planning your child's school day:

_____

_____

_____

Physician's Name: _____ Phone # _____

Dentist's Name: _____ Phone # _____

Eye Doctor's Name _____ Phone # _____

To the best of my knowledge the above information is complete and accurate. I acknowledge that I have a continuing obligation to inform the school of any changes in my child's health status that are relevant to the information requested by this form.

_____ _____

Parent/Guardian signature Date

Allen County Non-Public School Association

PHYSICIAN CERTIFICATE OF EXAMINATION FORM

(To be completed by your child's physician)

Name_____ Date of Birth____/____/____

Allergies_____

Current Medications

1._____Dosage_____ Time_____
2._____Dosage_____ Time_____
3._____Dosage_____ Time_____

Height_____ **Weight**_____ **B/P**_____ **Pulse**_____

Eyes _____
Ears_____
Nose_____
Throat_____
Chest/Lungs_____
Heart_____
Abdomen_____
Hernia_____
Extremities_____
Musculoskeletal_____
Neurological_____
Skin_____

Lab Work (If indicated)

Hematocrit _____
Hemoglobin _____
Lead Level _____
Sickle Cell _____
Urinalysis _____
Other _____

Tuberculin Test (if indicated)

Type of test_____
Date_____
Results_____

Is this student physically fit to participate in all physical education programs?

Yes_____ No_____ If no, please explain_____

_____

Please list any conditions that should be considered in planning this child's school day:

_____

_____

CONTINUED ON REVERSE

IMMUNIZATION HISTORY

*****PLEASE ATTACH A COPY OF THE CHILD'S FULL*****
IMMUNIZATION RECORD

All students must have an immunization record in the school office before the first day of school. This student MAY NOT attend school without a record of having received the required immunizations listed below. The only exception is to have a medical or religious exemption form filed with the school office.

The following immunizations are the minimum requirement by the State of Indiana for

Kindergarten – 3rd Grades

DTaP (5) IPV (4) Hepatitis B (3) MMR (2) Varicella (2) Hepatitis A (2)

4th -5th Grades

DTaP (5) IPV (4) Hepatitis B (3) MMR (2) Varicella (2)

6th-8th Grades

Previous listed plus an additional Tdap (1) and MCV (1)

(These are the minimum doses that are necessary. All minimum ages and intervals for each vaccination as specified in the CDC guidelines must be followed to be considered valid.)

_____
Printed or Stamped name of the Physician completing this form

_____ _____
Physician's signature **Date**

(revised ACNPSA 1/17)

Allen County Non-Public School Association

CHIRP Consent Form

The Indiana State Department of Health maintains an electronic immunization registry entitled Children and Hoosiers Immunization Registry Program (CHIRP). CHIRP allows all health care providers within the state of Indiana to enter and view immunization data with this method of electronic documentation. CHIRP ensures that the most up-to-date record of immunizations is available to all health care providers. The Indiana Department of Education mandates that all schools within the state of Indiana utilize CHIRP to document annual immunization reports. We are required to submit these immunization reports to maintain our accreditation. Parents/guardians within our school are being notified of this law and your permission is required to submit the immunization status of your child in this format. The Indiana Department of Education's attorney Dana Long, collaborating with the Indiana State Department of Health, has prepared the consent attached to this document.

I, as a parent/legal guardian to the below stated child, give _____ School, permission to release in addition to immunization data, the following information concerning my child to the the Indiana State Department of Health's Children and Hoosiers Immunization Registry Program (CHIRP):

_____	_____
Signature	Date
_____	_____
Printed Name of Parent(s)/Guardian(s)	
_____	_____
Address	City, State and Zip Code
_____	_____
Printed Full Name of Child	Birthdate of Child

Grade 2017-2018 _____

I understand that the information in the registry may be used to verify that my child has received proper immunizations and to inform me or my child of my child's immunization status or that an immunization is due according to recommended immunization schedules.

I understand that my child's information may be available to the immunization data registry of another state, a healthcare provider or a provider's designee, a local health department, an elementary or secondary school, a child care center, the office of Medicaid policy and planning or a contractor of the office of Medicaid policy planning, a licensed child placing agency, and a college or university. I also understand that other entities may be added to this list through amendment to I.C. 16-38-5-3.
I herby consent to the release of such information.

PLEASE RETURN AT REGISTRATION OR BEFORE FIRST DAY OF SCHOOL

(revised ACNPSA 1/17)

Allen County Non-Public School Association

CERTIFICATE OF DENTAL EXAMINATION

Please Print

Student's Name: _____
(Last) (First) (MI)

Date of Birth: ____/____/____ Enrolling in Grade _____

This Form is to be Completed by the Child's Dentist.

DENTAL EXAMINATION

Code: No Defect = 0 Defect = Note Condition

TEETH

1. **Cavities** _____
2. **Malocclusion** _____
3. **Soft Tissue** _____
4. **Oral Hygiene** _____
5. **Fluoride** _____
6. **Sealant** _____

PRESENT STATUS

Does this child presently have any tooth decay or other dental defects which may reduce his/her efficiency or prevent him/her from receiving the full benefit of his/her school work?
If yes, please explain _____
_____

FURTHER RECOMMENDATIONS

_____
_____

_____
Print/Stamp Dentist's Name **Signature**

_____
Date

(reviewed ACNPSA 1/17)

Allen County Non-Public School Association

STUDENT MEDICATION INFORMATION
AND
CONSENT FORM

I have read and understand the medication policies as indicated on the reverse side.

Please administer to my child _____, the **prescription medication(s)** written below. The label affixed to the medication bottle/package will meet the requirement for the physician's written order.

AND / OR

Please administer to my child _____, the **over-the-counter medication(s)** as described below:

(REMINDER: Prescription and over-the-counter medications must be kept in the original container with the pharmacy or brand label affixed.)

MEDICATION	Dosage mg. and # of tabs	Time to Be given	Time medication is to be discontinued	Reason for medication	Precautions/ Side Effects
1.					
2.					
3.					
4.					

_____ _____

Parent/Guardian Signature Date

MEDICATION POLICY ON REVERSE SIDE

(reviewed ACNPSA 1/17)

WRITTEN CONSENT FOR ADMINISTRATION OF MEDICATION

In order to protect the health and welfare of the students and school staff alike, Indiana laws require that parents/guardians consent, in writing, to the administration of medication. In order for the school nurse, volunteer school nurse, or a staff member to administer medications to your student, the medication form on the reverse side must be completed and signed. Please read carefully the school policies regarding medication administration during school hours.

1. The school must have on record a written order from the prescribing physician/practitioner and written consent from the parent/guardian for prescription medications. There must be a written request from the parent/guardian for Over-the-Counter (OTC) medications before they will be administered to a student at school. **(NOTE: The label on the prescription bottle/package will meet the requirement for physician's written order.)**

2. Medications prescribed and/or OTC meds should be kept in the original container with the pharmacy or brand label affixed. The label must include the following: Student's name, name of medication, dosage of medication, and prescribing physician/ practitioner (if applicable).

3. Herbal medications will not be given at school.

4. Medication brought to the school must be checked in at the office and kept in a locked cabinet.

5. Only a one-week supply of medication is to be brought to the school.

6. The parent/guardian shall accept the legal responsibility for the safe arrival of his/her child's medication to the school.

7. The school nurse/assigned staff member must be aware of the purpose for which the student is receiving the medication.

8. In specific cases, the school nurse/assigned staff member may require the parent/guardian to come to the school to administer the medication.

9. No school employee, other than the school nurse, will give injections, unless appropriate training has been given.

10. All prescribed medication will be administered strictly in accordance with the written order of the physician/practitioner. The dosage may be changed only if the school is provided with the written order of the physician/practitioner authorizing the change. The school secretary/staff cannot take a physician order over the phone.

11. Over-the-Counter medication will not be administered in any manner inconsistent with the instructions on the brand label, unless the school receives a written order of a physician/practitioner authorizing such administration.

IC 20-34-3-18 Indiana State Code reads that a school corporation MAY NOT send home with a student medication that is possessed by a school for administration during school hours or at school functions. Medication that is possessed by a school for administration during school hours or at school functions for a student in grades kindergarten through grade 8 may be released only to:

The student's parent/guardian OR an individual who is at least 18 years of age **and**, designated, **in writing,** by the student's parent/guardian to receive the medication.

A school corporation may send home medication that is possessed by a school for administration during school hours or at school functions with a student in grades 9-12 if the student's parent/guardian provides **written permission** for the student to receive the medication.

MEDICATION CONSENT FORM ON REVERSE SIDE

(reviewed ACNPSA 1/17)

Allen County Non-Public School Association

KINDERGARTEN VISION EXAMINATION

Name _____ Birthdate _____
(Last) (First) (MI)

Address _____

Examiner's Report

VISUAL ACUITY

	NEAR	FAR
R eye	_____	_____
L eye	_____	_____
Both	_____	_____

REFRACTION ERROR TEST

Results _____

OCULAR HEALTH TEST

Results _____

BINOCULAR COORDINATION TEST

Results _____

Has the Parent/Guardian been informed of any abnormalities or vision problems needing attention? YES _____ NO _____

Additional remarks or information which you feel might be of assistance to the school in promoting good vision health for this student:

_____

_____

Examining Eye Doctor's Signature _____ Date _____

Stamped or Printed Name, Address and Phone Number of Examining Eye Doctor:

_____

_____

_____

(rev ACNPSA 1/17)

2017-2018
FREE Pre-Kindergarten Vision Screening

The following Optometrists have volunteered to provide **FREE** kindergarten screenings in their offices. I encourage you all to take advantage of this rare FREE preventative health opportunity offered to families in the Allen County Non Public School Association (ACNPSA).

It is necessary to follow the guidelines below in order to ensure a free, professional vision screening.

1. Call one of the following offices and identify yourself and the non-public school your child will be attending.
2. **CALL for an appointment no later than JULY 1** and tell them that your appointment is for kindergarten screening.
3. Be sure to take this kindergarten vision screening report form with you for the optometrist to complete.

Dr. Thomas Baker 749-0407
1318 Minnich Rd. New Haven, IN

Dr. Aileen Heaston 489-3996
10301 Dawson's Creek Blvd. Suite A Ft. Wayne, IN

Dr. Troy Hockemeyer 493-1505
10848 Rose Ave, Suite 1 New Haven, IN

Dr. Myra Weber 486-8833
6110 Maplecrest Rd. Ft Wayne, IN

Dr. Thomas Zachman 432-1231
7625 W. Jefferson Blvd. Ft Wayne, IN

***We are most appreciative to the above optometrists for their services to the Allen County Non-Public Schools! At the time of your child's appointment, **PLEASE** give them a word of thanks for taking time out of their practice to give back to our community.

(rev ACNPSA 1/17)

Allen County Non-Public School Association

KINDERGARTEN VISION EXAMINATION

Name _____ Birthdate _____
(Last) (First) (MI)

Address _____

Examiner's Report

VISUAL ACUITY

	NEAR	FAR
R eye	_____	_____
L eye	_____	_____
Both	_____	_____

REFRACTION ERROR TEST

Results _____

OCULAR HEALTH TEST

Results _____

BINOCULAR COORDINATION TEST

Results _____

Has the Parent/Guardian been informed of any abnormalities or vision problems needing attention? YES _____ NO _____

Additional remarks or information which you feel might be of assistance to the school in promoting good vision health for this student:

_____

_____

Examining Eye Doctor's Signature _____ Date _____

Stamped or Printed Name, Address and Phone Number of Examining Eye Doctor:

_____

_____

_____

(rev ACNPSA 1/17)

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(rev ACNPSA 1/17)