EACS HEALTH SERVICES FORMS
Kindergarten Enrollment

Children who maintain good health avoid problems that may interfere with their ability to listen, concentrate, and learn.

Visiting your health care provider and dentist before school starts, provides an opportunity to identify potential problems.

Please complete and return by first day of school attendance:

- Immunization History Form
- Student Health Information Form
- Physical Examination Form
- Dental Examination Form
- Student Emergency Information Form
East Allen County Schools
HEALTH SERVICES
Immunization History - Kindergarten

STUDENT ________________________ Birth Date __________________

EACS requires the parent to supply immunization information no later than the first day of school; by one of the following: Doctor’s note with vaccine and date given; record maintained by the parent with vaccine and date given; immunization records from previous school; note of scheduled appointments from a doctor, Board of Health, or Super Shot. Students will be excluded from school for failure to provide required immunization information.

Immunization exemption based on religious beliefs or a medical condition will satisfy state requirements; however, parent/guardian must sign an Immunization Exemption (Hs-1a) form annually with a physician’s signature also required for a medical exemption. If there is a communicable disease outbreak, children with immunization exemption may be excluded from school.

TO BE COMPLETED BY HEALTH CARE PROVIDER OR CLINIC

CHICKENPOX DISEASE:
☐ YES, this child has had chickenpox. Date of illness (Mo/Yr) ___________ Health Care Provider’s Initials ___________

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Status</th>
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<tbody>
<tr>
<td>DTaP</td>
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<tr>
<td>DPT</td>
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<tr>
<td>DT</td>
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<tr>
<td>Polio...IPV</td>
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<tr>
<td>MMR</td>
<td>Measles only</td>
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<td></td>
<td>Mumps only</td>
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<td></td>
<td>Rubella only</td>
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<tr>
<td>Hepatitis A</td>
<td></td>
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<td>Hepatitis B</td>
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<tr>
<td>HIB</td>
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<td>Pneumococcal</td>
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<tr>
<td>Varicella</td>
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Other immunizations:

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<tr>
<th>Vaccine</th>
<th>Status</th>
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Most recent TB: Date ___________ Type ___________ Results ___________

Scheduled appointments for incomplete immunizations: __________________________________________

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<thead>
<tr>
<th>Health Care Provider’s Signature &amp; Initial</th>
<th>Name Printed</th>
<th>Date</th>
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Parent or Legal Guardian Signature

Date

EACS Hs 1_1
(2015)
East Allen County Schools
HEALTH SERVICES
Student Health Information - Kindergarten

TO BE COMPLETED BY PARENT OR GUARDIAN

Student Name ___________________________ Birth Date __________________ Sex M F
Street Address ___________________________ Phone __________________

Father’s Name ___________________________ Mother’s Name ___________________________

Legal Guardian’s Name ___________________________ Relationship ___________________________

Family Physician ___________________________ Office Phone Number ___________________________
Dentist ___________________________ Office Phone Number ___________________________

Give DATE if known or mark “X” if your child has or had disease or condition:

ADD/ADHD Measles (Hard) Measles (Rubella) Scarlet Fever Hepatitis
Seizure (fever) Mononucleosis Tuberculosis Meningitis Mumps
Rheumatic Fever Whooping Cough Pneumonia Chickenpox disease date ____________

Additional medical information:

Allergies □ NO Known Allergies □ YES, □ Seasonal □ Food □ Insect Sting/Bite □ Other ____________

Treat allergic reaction with: □ none required □ oral medication □ EpiPen / Auvi Q

Has your child ever had an anaphylactic reaction? □ NO □ YES, explain ___________________________

Asthma □ NO □ YES If yes, will require inhaler while at school? □ NO □ YES

Diabetes □ NO □ YES If yes, □ Type I (insulin dependant) □ Type II (control with diet and oral medication)

Epilepsy □ NO □ YES

Bleeding disorder □ NO □ YES If yes, explain ___________________________

Heart condition □ NO □ YES If yes, explain ___________________________

Kidney/bladder condition □ NO □ YES If yes, explain ___________________________

Sickle Cell □ NO □ YES If yes, □ Disease or □ Trait?

Vision □ No problems □ wears glasses □ wears contacts

Hearing □ No problems □ wears aides, □ right ear □ left ear Seat to front of classroom □ NO □ YES

Speech □ No problems □ Has some difficulty, want the speech therapist informed? □ NO □ YES

Diet restrictions _________________________________________________________________

Other medical conditions _________________________________________________________

Emotional/psychological conditions _______________________________________________

Medications taken daily by your child at home and school: _________________________________________________________________

Signature of Parent or Legal Guardian ___________________________ Date ___________________________

**ADDITIONAL HEALTH INFORMATION MAY BE NOTED ON BACK OF THIS FORM**
**STUDENT EMERGENCY INFORMATION**

**To be completed by custodial parent or legal guardian**

Student's Name ____________________________  Sex  M - F  Birth Date _______________  Grade ________

Street Address ____________________________  City and Zip ____________________________

Student lives with:  ____ Parents  ____ Father  ____ Mother  ____ Foster/Residential Care  ____ Other ______

*LEGAL GUARDIAN* ____________________________  Home Email Address ____________________________

Father's Name ____________________________  Home Phone ____________________________  Cell __________

Place of employment ____________________________  Work Phone ____________________________  Work Email __________

Mother's Name ____________________________  Home Phone ____________________________  Cell __________

Place of employment ____________________________  Work Phone ____________________________  Work Email __________

Family Physician ____________________________  Office Phone ____________________________

Dentist ____________________________  Office Phone ____________________________

**IN CASE OF ILLNESS OR EMERGENCY AT SCHOOL,** I understand every effort will be made to contact the parent or guardian. *When this fails,* the following person(s) may be contacted to speak on behalf of the parent or guardian concerning this student. *Emergency contacts are family and/or friends* the parent or guardian entrusts with their child. *Emergency contacts* should live a short drive from the school and be available during the school day to pick up sick or injured students. We encourage you to have more than one emergency contact person. If none of the designated contacts can be reached, and a serious medical emergency exists requiring medical treatment beyond what is provided at school to maintain safety and/or life, this student may be transported by EMS to ____________________________ hospital.

#1 Name ____________________________  Phone # ____________________________  Relationship ______

#2 Name ____________________________  Phone # ____________________________  Relationship ______

#3 Name ____________________________  Phone # ____________________________  Relationship ______

**COMPLETE REQUESTED HEALTH INFORMATION THAT APPLIES TO THIS STUDENT.** This information will be on file in the school clinic. All student health information is considered confidential and shared only if the health condition may impede classroom achievement on a “need to know” basis. *ALL medication MUST be supplied to the school by the parent or guardian.* The school does NOT STOCK any medication.

**ALLERGIES:**  ☐ NO  ☐ YES  ☐ Milk Allergy  ☐ Lactose Intolerant  ☐ Other: ____________________________

Describe reaction: ____________________________

Requires medication?  ☐ Yes  ☐ No  ☐ No  ☐ Yes  ☐ Other: ____________________________

**ASTHMA:**  ☐ NO  ☐ YES  ☐ Activity Induced  ☐ Allergy Induced  ☐ Anxiety Induced  ☐ Other: ____________________________

On a scale from 1 (very mild) to 10 (severe) rate your child's asthma (circle appropriate number) 1 2 3 4 5 6 7 8 9 10

Asthma control regimen ____________________________  Will your child use/carry an inhaler at school?  ☐ No  ☐ Yes

Students that carry and self-administer inhalers must have a completed *Medication Self-Administration Consent Form* (Hs-5b) on file.

**ATTENTION DEFICIT DISORDER:**  ☐ NO  ☐ YES:  ☐ Without Hyperactivity (ADD)  ☐ With Hyperactivity (ADHD)

Medication required during school hours?  ☐ NO  ☐ YES

**DIABETES:**  ☐ NO  ☐ YES: Age Diagnosed ____  Controlled by:  ☐ Diet Only  ☐ Diet and Oral Medication  ☐ Insulin Dependent

Additional Information ____________________________

~ An *EACS Diabetes Medical Management Plan* MUST be completed by the physician and parent/guardian, contact the school nurse.

**EPILEPSY:**  ☐ NO  ☐ YES: List Type ____________________________  Controlled with ____________________________

How frequent is seizure activity? ____________________________  Known Triggers ____________________________

Describe typical seizure: ____________________________

**Vision**  ☐ No problems  ☐ wears glasses  ☐ wears contacts

**Hearing**  ☐ No problems  ☐ wears aids  ☐ Other, explain: ____________________________

List other medical/psychological conditions, disorders, and/or diseases ____________________________

(Use back of form if additional space is needed)

List ALL daily medications (home and school)—dosage, time given, and reason for medication ____________________________

I authorize East Allen County Schools, to copy this form and give to emergency medical personnel in the event of a medical emergency requiring EMS transport.

PARENT/GUARDIAN SIGNATURE ____________________________  Date ____________________________

**** RETURN THIS FORM TO THE SCHOOL NURSE ****
Student's Name__________________________ Birth Date__________ Male--Female (Circle)

Home Address ________________________________ School ____________________

Parent/Legal Guardian Name ____________________ Home Phone __________________

**TO BE COMPLETED BY HEALTH CARE PROVIDER**

HT _______ WT _______ B/P _______ LEAD TEST: Date __/__/____ [] capillary or [] venous results

*lead testing only if physician deems applicable

Vision Right 20/ _______ Left 20/ _______ Corrected: ☐ Yes ☐ No

Pupils (circle) Equal Unequal R>L L>R

<table>
<thead>
<tr>
<th>Physical Examination</th>
<th>Normal</th>
<th>Abnormal</th>
<th>Comments</th>
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<tbody>
<tr>
<td>General Appearance</td>
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<tr>
<td>Neurological</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ears</td>
<td></td>
<td>Chronic infections ☐ Yes ☐ No</td>
<td>Tubes ☐ R ☐ L ☐ Both</td>
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<tr>
<td></td>
<td></td>
<td>Permanent Loss ☐ Yes ☐ No</td>
<td>Aided ☐ R ☐ L ☐ Both</td>
</tr>
<tr>
<td>Throat</td>
<td></td>
<td>Tonsils-adenoids (circle) Normal Enlarged Removed</td>
<td></td>
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<tr>
<td>Lungs</td>
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<td>Heart</td>
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<td>Abdomen</td>
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<td>Skin</td>
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<tr>
<td>Spinal Screening</td>
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</table>

**Significant Medical History**

Allergies ☐ NO ☐ Yes:

Alaphylactic Reaction ☐ NO ☐ Yes:

Diabetes ☐ No ☐ Yes:

Epilepsy ☐ No ☐ Yes:

Marfan's Syndrome ☐ No ☐ Yes:

Rheumatic Fever ☐ No ☐ Yes:

Other:

**RECOMMENDATION FOR PHYSICAL EDUCATION:** Full Program _______ Restricted _______

If restricted, explain: _____________________________________________________________

_________________________________________ Date _____________________

Health Care Provider's Signature ____________________________ Date __________________

Health Care Provider's Name PRINTED ____________________________________________

EACS Hr-3 2014
To be completed by parent or legal guardian (please print):

<table>
<thead>
<tr>
<th>Student's Name:</th>
<th>Last</th>
<th>First</th>
<th>Middle</th>
<th>Birth Date: (Month/Day/Year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td>Street</td>
<td>City</td>
<td>Zip Code</td>
<td>Home Phone Number:</td>
</tr>
<tr>
<td>Name of School:</td>
<td></td>
<td>Grade Level:</td>
<td>Gender:</td>
<td></td>
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<tr>
<td>Parent or Legal Guardian:</td>
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</tbody>
</table>

TO BE COMPLETED BY DENTIST:

- [ ] Yes  [ ] No  Dental Sealants Present

- [ ] Yes  [ ] No  Untreated decay in deciduous teeth
- [ ] Yes  [ ] No  Untreated decay in permanent teeth

If yes, to either or both of the above answer the following:

- [ ] Yes  [ ] No  Decay is classified as early childhood caries/baby bottle caries (affecting the primary maxillary anterior teeth, followed by involvement of the primary molars; mandibular incisors may not be affected)
- [ ] Yes  [ ] No  Decay is classified as rampant caries in permanent teeth
- [ ] Yes  [ ] No  Child is experiencing pain and/or infection

- [ ] Yes  [ ] No  Malocclusion

Oral hygiene  [ ] optimal for age  [ ] needs improvement

- [ ] Yes  [ ] No  This is child’s first dental examination
- [ ] Yes  [ ] No  All necessary dental treatment completed
- [ ] Yes  [ ] No  If no above, appointments are scheduled to complete necessary treatment

COMMENTS:

Signature of Dentist ___________________________________________ Office Phone ______________________

Dentist’s name PRINTED _______________________________________ Date ______________________