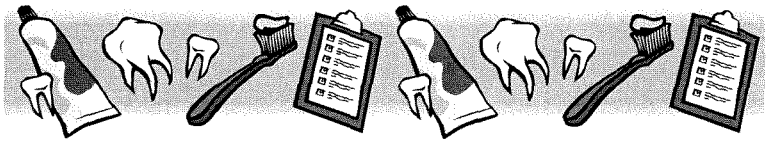
EACS HEALTH SERVICES FORMS

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
Student Emergency Information Form
Physical Examination Form
Dental Examination 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 may 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 _____

DTaP					
DPT					
DT					
Polio...**OPV**					
Polio...**IPV**					
MMR					
	Measles only				
	Mumps only				
	Rubella only				
Hepatitis **A**					
Hepatitis **B**					
Varicella					
Pneumococcal					
HIB					

Other immunizations:

Most recent TB: Date _____ Type _____ Results _____

Scheduled appointments for incomplete immunizations: _____

Health Care Provider's Signature & Initial **Name Printed** **Date**

Parent or Legal Guardian Signature **Date**

East Allen County Schools
HEALTH SERVICES
Student Health Information - Kindergarten

TO BE COMPLETED BY PARENT OR GUARDIAN

Student Name _____ Birth Date _____ Sex **M** **F**

Father's Name _____ **Mother's Name** _____

Legal Guardian's Name _____ Relationship _____

Family Physician _____ Office Phone Number _____

Dentist _____ Office Phone Number _____

Check the health conditions that affect your child or have had in the past:

☐ ADD/ADHD ☐ G.I Disorder ☐ Malignancy (cancer) ☐ Neurological Disorder
☐ Cystic Fibrosis ☐ Hepatitis ☐ Meningitis ☐ Pneumonia

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 been hospitalized due to allergic 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 (seizures) ☐ 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

East Allen County Schools
HEALTH SERVICES

STUDENT *EMERGENCY* INFORMATION

To be completed by custodial parent or legal guardian

Bus Walk Parent transport Student drives self
(Circle all that apply)

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** Known Allergies ☐ **YES** ☐ Milk Allergy ☐ Lactose Intolerant ☐ Other: _____

Describe reaction: _____

Requires medication? ☐ Yes ☐ No Has your child ever had a severe reaction requiring hospitalization? ☐ No ☐ Yes

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 regime _____ 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 aides ☐ 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 _____

EACS Hs-9 2018

**** BRING TO REGISTRATION - RETURN THIS FORM TO THE SCHOOL NURSE ****

East Allen County Schools
HEALTH SERVICES
Physical Examination – Kindergarten

Student's Name _____ Birth Date ____/____/_____ ☐ Male ☐ Female

Parent/Legal Guardian Name _____

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 ☐ Equal ☐ Unequal ☐ R>L ☐ L>R

Physical Examination	Normal	Abnormal	Comments
General Appearance			
Neurological			
Ears			Chronic Infections ☐ No ☐ Yes Tubes ☐ R ☐ L ☐ Both
			Permanent Loss ☐ No ☐ Yes Tubes ☐ R ☐ L ☐ Both
Throat			Tonsils-adenoids ☐ Normal ☐ Enlarged ☐ Removed
Lungs			
Heart			
Abdomen			
Hernia			
Extremities			
Skin			
Spinal Screening			

Significant Medical History

Allergies ☐ No ☐ Yes, explain _____

History of Anaphylactic Reaction ☐ No ☐ Yes, cause _____

Asthma ☐ No ☐ Yes - Inhaler needed at school ☐ No ☐ Yes, _____

Attention Deficit Disorder ☐ No ☐ Yes, with hyperactivity ☐ No ☐ Yes, _____

Diabetes ☐ No ☐ Yes, _____

Epilepsy ☐ No ☐ Yes, _____

Other conditions/disabilities _____

List daily medications _____

RECOMMENDATION FOR PHYSICAL EDUCATION: ☐ Full Program ☐ Restricted

If restricted, explain: _____

_____

Health Care Provider's Signature _____ Date _____

Health Care Provider's Name PRINTED _____

East Allen County Schools
HEALTH SERVICES
Dental Examination

To be completed by parent or legal guardian (please print):

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

TO BE COMPLETED BY DENTIST:

☐ No ☐ Yes Dental Sealants Present

☐ No ☐ Yes Untreated decay in **deciduous teeth**
☐ No ☐ Yes Untreated decay in **permanent teeth**
If yes, to either or both of the above answer the following:

☐ No ☐ Yes 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)
☐ No ☐ Yes Decay is classified as *rampant caries* in permanent teeth
☐ No ☐ Yes Child is experiencing *pain and/or infection*

☐ No ☐ Yes Malocclusion

Oral hygiene ☐ optimal for age ☐ needs improvement

☐ No ☐ Yes This is child's first dental examination
☐ No ☐ Yes All necessary dental treatment completed
☐ No ☐ Yes If no above, appointments are scheduled to complete necessary treatment

COMMENTS: _____

_____

_____

Signature of Dentist _____ Office Phone _____

Dentist's name PRINTED _____ Date _____