Saint Elizabeth Ann Seton Catholic School
10650 Aboite Center Road
Fort Wayne, Indiana 46804 (260)432-4001

Contents:

Important Information for Preschool

Required Forms

- ☐ Health Questionnaire- Needs completed and returned to the school by August 4, 2026.
- ☐ Physician Certificate of Examination Form- Must be completed by the student's physician and returned to the school by August 4, 2026.
- ☐ Immunization records-Please obtain a copy of your child's immunization record and return to school no later than August 4,2026. ☐

CHIRP Consent Form- Must be completed, signed, and returned to school by August 4, 2026.

If your student has diabetes, asthma, food allergies, or the need for an Epi-Pen or inhaler while at school, additional forms will need completed.

All forms should be returned to the school office <u>no later</u> than the first day of school

**A <u>current</u> copy of immunization records

must be on file for all students**

About Immunizations:

IC 20-34-4-2 requires that all students residing in Indiana be immunized following the ACIP (Advisory Committee on Immunization Practices) and Indiana Department of Health guidelines. These mandatory vaccinations include DTaP (4), IPV (3), Hepatitis B (3), MMR (1), Varicella (1), 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 do not 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. Please 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. **Failure to provide appropriate documentation of immunizations may result in your child being exempt from school until records are received.**

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. Turning off the TV at least 30 minutes before bedtime helps children unwind and is a great time to read to children!

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 temperature 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. 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 into 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. Remember 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 "Medication Consent" form. If you have any questions, please contact the school nurse.

HEALTH QUESTIONNAIRE

Parent / Guardian to complete
This is an annual form for preschool. Please contact the school with any updates or changes.

Student Name:_____ Grade:_____ Date of Birth:_____

Address:_____

Phone Number:_____Student lives with:_____

Father's Name:_____ Mother's Name:_____

Health History

Disease/Condition (please circle)			**Disease/Condition** (please circle)		
Seasonal allergies	Yes	No	Measles/Mumps/Rubella	Yes	No
*Food allergy	Yes	No	Scarlet Fever	Yes	No
*Asthma	Yes	No	Pneumonia	Yes	No
ADD/ADHD	Yes	No	Heart Murmur	Yes	No
Chicken Pox	Yes	No	Emotional disorder	Yes	No
*Diabetes	Yes	No	Bowel or bladder issues	Yes	No
Diphtheria	Yes	No	Mononucleosis	Yes	No
Ears/Infections	Yes	No	Hepatitis	Yes	No
Epilepsy	Yes	No	Tuberculosis	Yes	No
*Seizures	Yes	No	Whooping Cough	Yes	No
Rheumatic Fever	Yes	No	Other	Yes	No
Handicaps/Impairments (Hearing/Physical/Vision)	Yes	No			

** Additional forms required- see school nurse*

For any 'yes' circled above, please give explanations and dates of diagnoses.

_____

_____

_____

Has your child had an infectious/communicable disease other than those listed above? Yes ___ No ___

If yes, please explain, giving relevant dates: _____

Has your child ever been prescribed an Epi-Pen or Auvi-Q Injector due to an allergy? Yes ___ No ___

If yes, please explain, giving relevant dates: _____

Medication allergies: _____

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Both sides must be completed

HEALTH QUESTIONNAIRE

Student Name _____

Please list any of the following with month/year:

Operations: _____

Severe Illnesses: _____

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

_____

Hospitalizations: _____

_____

Diagnostic 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 conditions that should be considered in planning your child's school day: _____

_____

_____

Physician Name: _____ Phone:_____

Dentist Name: _____Phone:_____

Eye Doctor 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

Both sides must be completed

10650 Aboite Center Road, Fort Wayne, IN 46804 • (260) 432-4001 • info@seascsfw.org • www.seasfw.org

Physician Certificate of Examination Form

(To be completed by the child's physician)

Name_____ Date of Birth____/____/____

Medication Allergies _____

Current Medications: (list name, dosage, and time)

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_____

Check only if applies:
(If checked, require additional forms with care plan for school, signed by physician.)

- ☐ Asthma
- ☐ Food Allergies
- ☐ Need for Epi-Pen
- ☐ Heart Condition
- ☐ Diabetes
- ☐ Other _____

List Abnormal Results: _____

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

Yes_____ No_____ If no, please explain_____

_____

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

_____

Physicians Printed Name: _____

Signature: _____

Date of Exam: _____

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

Preschool

DTaP (4) IPV (3) Hepatitis B (3) MMR (1) Varicella (1) Hepatitis A (2)

Kindergarten –5th Grades

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

6th - 8th Grades

Previous listed plus additional Tdap (1) and MCV4 (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 in the State of Indiana.)

_____
Printed or Stamped name of the Physician completing this form

_____ _____
Physician's signature **Date**

(revised ACNPSA 1/20)

CHIRP Consent Form

Required form for all students' health files – Please return ASAP

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 helped prepare the wording of the below consent.

I, as a parent/legal guardian to the below stated child(ren):

☐ Give consent to Saint Elizabeth Ann Seton Catholic School to release such information

☐ I DO NOT give consent to Saint Elizabeth Ann Seton Catholic School to release of such information

to the Indiana State Department of Health's Children and Hoosiers Immunization Registry Program (CHIRP):

Student's name, immunization data, and other information such as date of birth or other identifying information as applicable.

(For filing purposes, please list all students regardless of consent status)

_____Grade: _____ Birthdate: ____/____/____
_____Grade: _____ Birthdate: ____/____/____
_____Grade: _____ Birthdate: ____/____/____
_____Grade: _____ Birthdate: ____/____/____
_____Grade: _____ Birthdate: ____/____/____
_____Grade: _____ Birthdate: ____/____/____
_____Grade: _____ Birthdate: ____/____/____

I understand that the information in the registry may be used to verify that my child has received proper immunization 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 date registry of another state, a healthcare provider or a provider's designees, a local health department, an elementary or secondary school, a childcare center, the office of Medicaid policy and planning or a contractor of the office of Medicaid policy and 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.

_____ _____
Signature Date

_____ _____
Printed Name of Parent or Guardian Telephone #

_____
Address

Once signed, this form will apply to all years your student is attending Saint Elizabeth Ann Seton Catholic School