Kindergarten Health Forms 2026-2027

Contents:

Required Forms

- ☐ Copy of Current Immunization Records
- ☐ Kindergarten MCT Vision Screening Form
- ☐ Dental Exam Form
- ☐ Physician Certificate of Examination Form
- ☐ Health Questionnaire Form
- ☐ CHIRP Consent Form

Medication Policy and Consent Form*

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

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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. This includes the Health Questionnaire, CHIRP Consent, Physical Exam, Dental Exam, Vision Exam and a copy of your child's up to date immunizations or exemption.

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 teaching and 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!

About Kindergarten 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.

Vision: 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 for a limited time.**

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 and submitted to the school office no later than the first day of school.**

Dental: Kindergarten students are required to have the "Dental Examination" form completed prior to their first day of school. But, we encourage all of our students to visit their dentist regularly as it is an important part of our general health and well-being. **The "Dental Exam" form is to be submitted to the school office no later than the first day of school.**

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 filled out by the parents/guardians. **These forms must be submitted to the school office no later than the first day of school.**

CHIRP: As required by IC 20-34-4-6, we report immunizations to the State Department of Health. 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. **This form needs to be submitted to the school office no later than the first day of school.**

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.

The only exception to this rule is a signed "Medical Exemption" form filled out by your child's physician (IC 20-34-33-3), or a "Religious Objection" form signed by the parents/legal guardians (IC 20-34-3-2) stating that it is against your family's religious beliefs. Please contact the nurse if you need either of these forms.

Unfortunately, if this is not completed by the first day of school, you will receive a letter excluding your child from school until the immunizations have been obtained and proper paperwork has been filed.

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 100.4 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. 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.

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. We need your consent via this form to add your child to our school data. 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(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):

STUDENTS 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: ____/____/____

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.

_____ _____
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

HEALTH QUESTIONNAIRE

Parent / Guardian to complete

For any updates or changes to your student's information, please contact the school.

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)		
ADD/ADHD	Yes ☐	No ☐	Hepatitis	Yes ☐	No ☐
*Allergy Seasonal	Yes ☐	No ☐	Measles/Mumps/Rubella	Yes ☐	No ☐
*Allergy Food	Yes ☐	No ☐	Mononucleosis	Yes ☐	No ☐
*Allergy Other	Yes ☐	No ☐	Pneumonia	Yes ☐	No ☐
*Asthma	Yes ☐	No ☐	Rheumatic Fever	Yes ☐	No ☐
Chicken Pox	Yes ☐	No ☐	Scarlet Fever	Yes ☐	No ☐
*Diabetes	Yes ☐	No ☐	*Seizures	Yes ☐	No ☐
Chronic Ear Infections	Yes ☐	No ☐	Tuberculosis	Yes ☐	No ☐
Emotional disorder	Yes ☐	No ☐	Whooping Cough	Yes ☐	No ☐
GI/GU Issues	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: _____

Both sides must be completed

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HEALTH QUESTIONNAIRE

Student Name _____

Please list any of the following with month/year:

Surgical Procedures: _____

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

Page 2 of 2
Both sides must be completed

Physician Certificate of Examination Form

(To be completed by the child's physician)

This is not an annual form. For any updates or changes to your student's information, please contact the school.

Name_____ Date of Birth____/____/____

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: _____

(revised ACNPSA 2/26)

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 2/26)

Kindergarten Certificate of Dental Examination

Please Print

Student's Full Name_____

Date of Birth_____ Enrolling grade_____

This form is to be completed by child's dentist.

Dental Exam

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 schoolwork? If yes, please explain_____

_____

FURTHER RECOMMENDATIONS

_____

_____

Print/Stamp Dentist's Name Signature

_____

Date

(revised ACNPSA 2/26)

Kindergarten MCT Vision Examination

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

Examiner's Report

ALL AREAS must be filled out to be considered a complete exam by the State of Indiana.

VISUAL ACUITY. Near and Far must both be done for this exam.

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

REFRACTIVE EYE EXAM	**PASS**	**FAIL**
OCULAR HEALTH (Both Internal and External)	**PASS**	**FAIL**
EYE BINOCULAR COORDINATION EXAM	**PASS**	**FAIL**

Has the parent/guardian been advised of any abnormality? YES _____ NONE _____

Has the child been prescribed eyeglasses at this time? 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:

_____

_____

_____

(revised ACNPSA 1/20)

2026-2027
FREE Kindergarten MCT 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 your 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. When you call for an appointment, 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 — (May, June and July ONLY)

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

Aboite Family Eye Care Center — 432-1231
Dr. Kathryn Zachman
Dr. Michael Pavell
7625 W. Jefferson Blvd Fort 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.

(revised ACNPSA 2/26)

Student Medication Consent Form

Only one student's name per form

Name of student _____**Age:** _____ **Grade**_____ **Teacher:** _____

**Medications forgotten to be given at home will not be given at school, ONLY medications that fall within school hours will be given.

Medication **REMINDER: Prescription and over-the-counter medications must be kept in the original container with the pharmacy or brand label affixed. Medications will only be given as either prescribed by the practitioner or the FDA instructions that are found on the OTC medication label**	Dosage	When to be given	Expiration date on medication	Reason for medication
1.				
2.				
3.				

NO MODIFICATIONS OF DOSAGE OR FREQUENCY WITHOUT THE WRITTEN CONSENT BY THE CHILD'S HEALTHCARE PROVIDER.

For Prescription Medication(s): Please administer the medication as prescribed above by my child's healthcare provider. The label affixed to the medication bottle/package will meet the requirement for the physician's written order.
For Over-The-Counter Medication(s): Please administer the medication as described above.

MEDICATION POLICIES AND 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 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. The parent/guardian shall accept the legal responsibility for the safe arrival of his/her child's medication to the school.
6. The school nurse/assigned staff member must be aware of the purpose for which the student is receiving the medication, and be trained on "Medication Administration Procedure" by ACNPSA nurse.
7. In specific cases, the school nurse/assigned staff member may require the parent/guardian to come to the school to administer the medication.
8. No school employee, other than the school nurse, will give injections, unless appropriate training has been given.
9. 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.
10. 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.

I have read and understand the medication policies as indicated above.

_____ _____ _____

Parent/Guardian Signature **Date** **Phone #**