New Family Health Forms

Contents:

Required Forms

- ☐ Copy of Current Immunization Records
- ☐ CHIRP Consent Form
- ☐ Health Questionnaire
- ☐ Physician Certificate of Examination Form

Medication Policy and Consent Form*

<u>All forms are required</u> 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**

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.

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: _____

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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**

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