School Registration Form

SACRED HEART CATHOLIC SCHOOL
234 N. SYCAMORE ST.
MONTICELLO, IA 52310

FAMILY NAME	FATHER'S NAME	MOTHER'S NAME
HOUSE NUMBER	STREET	CITY AND ZIP
FATHER'S PHONE	FATHER'S EMAIL	FATHER'S PLACE OF WORK
MOTHER'S PHONE	MOTHER'S EMAIL	MOTHER'S PLACE OF WORK

NAME OF PERSON TO CONTACT IN CASE OF EMERGENCY WHEN PARENTS CANNOT BE REACHED:

NAME _____ PHONE _____

NAME _____ PHONE _____

DAYCARE _____ PHONE _____

CHILD	GRADE	BIRTHDATE

TURN OVER

CATHOLIC: YES_____ NO_____

PLEASE NAME PARISH, OR CHURCH, IF OTHER THAN SACRED HEART:

_____

IF CATHOLIC, PLEASE PROVIDE A BAPTISMAL RECORD FOR EACH CHILD ENTERING SACRED HEART SCHOOL.

CHILD'S FULL NAME	PARISH WHERE BAPTIZED
_____	_____
_____	_____
_____	_____
_____	_____

MOTHER'S MADEN NAME: _____

PLEASE NAME SCHOOL DISTRICT IF OTHER THAN MONTICELLO:

_____

DOES YOUR CHILD HAVE ANY MEDICAL CONCERNS THAT THE TEACHERS SHOULD BE AWARE OF? I.E. LOSS OF HEARING, HEART-MURMUR, ETC. IF SO, PLEASE DESCRIBE THE CONDITION.

_____

IF THE CHILD'S PARENTS ARE SEPARATED/DIVORCED, DOES THE SCHOOL HAVE THE RIGHT TO COMMUNICATE WIH BOTH PARENTS? OUR SCHOOL OFFICE DOES REQUIRE A CUSTODY AGREEMENT ON FILE. YES NO

_____ _____

PARENT/GUARDIAN SIGNATURE DATE

Sacred Heart School
Medication Permission Form
2025-2026 School Year

Medications may be administered to students at school only with written parental/guardian consent. No medications may be dispensed without a completed medication permission form. Additional forms are always available in the office for any changes.

Prescription medications must be in the labeled prescription container with the most current prescription and the prescribing doctor's name on the label. The label must also contain the child's name and administrating directions. Please send a one-month supply at a time. If the medication needs to be sent home with the student at the end of the day or the end of the week, please contact the school office. When obtaining a prescription at the pharmacy, please request a second labeled bottle to put the medication in to keep at school.

Non-prescription (over the counter) medications must be in their original container with the student's name written on the container. Medications to be given "as needed" may be sent to school also, but clear, written instructions for the dosage should be included. The school will have Children's Tylenol (both liquid and pill form) and Ibuprofen (both chewable and non) on hand for students to take if needed. We are not able to give your child ANY medication, including the school's medication without written consent.

I hereby give permission for the designated trained staff person(s)at Sacred Heart Catholic School to administer the following medication to the student named below:

Student Name:_____

School Medication (please circle all that apply) Tylenol Ibuprofen None

Medication Name From Home: _____

Dosage to be Given: _____

Inhaler or EPI Pen: If your student is currently using an inhaler or EPI Pen, please contact the office, as an addition form for self-administration is required.

Parent/Guardian Signature: _____

Date: _____

Please complete this form for each child in your family and return the form to the school.

Health Information

The following health documents are required for entrance into Sacred Heart School:

Iowa Department of Health Certificate of Immunization –
(required for all students) *The certificate needs to be signed and dated by the health care provider.*

Physical Examination Form –
(required for entrance into Kindergarten) A health care provider will update immunizations. *Lead level – it is mandatory that Kindergarten students have at least one lead level on record in their school health file.*

Iowa Department of Public Health Certificate of Dental Screening –
(required for Kindergarten)

Iowa Department of Public Health Certificate of Vision Screening –
(required for Kindergarten and again for third grade – one year before entering or no later than six months after entering Kindergarten and third grade)

Green Student Vision Card –
(required for Kindergarten)

Following are resources from the Iowa Department of Public Health:

Getting Ready for School in Iowa
https://idph.iowa.gov/Portals/1userfiles/142/readiness%20brochure%20FINAL.pdf

Kindergarten is starting soon ... is your child ready?
https://idph.iowa.gov/Portals/1Files/FamilyHealth/kindergarten_brochure.pdf

IMMUNIZATION CLINICS:

For Jones County Residents:
Contact Jones County Community Health @ 319 - 462-6945.

For Delaware County Residents:
Contact Delaware County Community Health @ 563-927-7551

IOWA | Health and Human Services

Certificate of Immunization

Jones County Public Health
104 Broadway Place
Anamosa, IA 52205
(319)462-6135 ext. 6223

Name Last: _____ First: _____ Middle: _____ Date of Birth: _____

Parent/Guardian: _____ Address: _____ Phone: (____)_____

A representative of the local Board of Health or Iowa Department of Health and Human Services may review this certificate for audit purposes.

Vaccine	Vaccine Type	Date Given	Source
Diphtheria, Tetanus, Pertussis DTaP/DTP/ DT/Td/Tdap			
Polio IPV/OPV			
Measles, Rubella MMR			
Haemophilus influenzae type b Hib			

Vaccine	Vaccine Type	Date Given	Source
Hepatitis B Hep B			
Varicella* Chickenpox			
Pneumococcal PCV			
Meningococcal MenACWY			

* If patient has a history of natural disease, write "Immune to Varicella".

I certify the above named applicant has a record of age-appropriate immunizations that meet the requirement for licensed child care or school enrollment.

Name (Print): _____
Physician (MD, DO), Physician Assistant, Nurse, or Certified Medical Assistant

Signature: _____ Date: _____
Physician (MD, DO), Physician Assistant, Nurse, or Certified Medical Assistant

July 2024

IOWA | Health and Human Services

IMMUNIZATION REQUIREMENTS
ELEMENTARY OR SECONDARY SCHOOL (K-12th GRADE)

Applicants enrolled or attempting to enroll shall have received the following vaccines in accordance with the doses and age requirements listed below.

Age	Vaccine	Total Doses Required
4 years of age and older	Diphtheria/ Tetanus/ Pertussis [2]	**5 doses** with at least 1 dose received on or after 4 years of age; or **4 doses** if the fourth dose was received on or after 4 years of age; and **1 dose** of tetanus/diphtheria/acellular pertussis-containing vaccine (Tdap) received on or after 10 years of age for applicants in grades 7 and above, regardless of the interval since the last tetanus/diphtheria-containing vaccine.
	Polio[1]	**4 doses** with at least 1 dose received on or after 4 years of age; or **3 doses** if the third dose was received on or after 4 years of age.
	Measles/Rubella	**2 doses**; or the applicant demonstrates a positive antibody test for measles and rubella from a U.S. laboratory.
	Hepatitis B	**3 doses**
	Varicella	**2 doses**; or the applicant has a reliable history of natural disease.
	Meningococcal (A, C, W, Y)	**1 dose** received on or after 10 years of age for applicants in grades 7 through 11; and **2 doses** with 1 dose received on or after 16 years of age for applicants in grade 12; or **1 dose** for applicants in grade 12 if the dose was received on or after 16 years of age.

1 Doses of oral polio vaccine (OPV) administered on or after April 1, 2016, are not valid doses and do not count toward the polio vaccine requirement.

2 Applicants 7 through 18 years of age who received the first dose of diphtheria/tetanus/pertussis-containing vaccine at 12 months of age or older should receive a total of 3 doses, with one dose received on or after 4 years of age.

Iowa Department of Public Health
CERTIFICATE OF DENTAL SCREENING

This certificate is not valid unless all fields are complete.
A designee of the local board of health or Iowa Department of Public Health may review this certificate for survey purposes.

Please Print:

Student's Last Name:	Student's First Name:	Birth Date (M/D/YYYY):
Parent or Guardian Name:	Telephone (home): (mobile):	
Address: Street	City:	County:
Name of School:	Grade Level:	Gender: ☐ Male ☐ Female

Treatment Needs (check ONE):

☐ Yes ☐ No **No Obvious Problems** – the child's hard and soft tissues appear to be visually healthy and there is no apparent reason for the child to be seen before the next routine dental checkup.

☐ Yes ☐ No **Requires Dental Care** – tooth decay or a white spot lesion is suspected in one or more teeth.

☐ Yes ☐ No **Requires Urgent Dental Care** – obvious tooth decay is present in one or more teeth, the child is experiencing pain, or there is evidence of infection or injury.

Definitions:

Tooth decay: A visible cavity or hole in a tooth with brown or black coloration, or a retained root.

White spot lesion: A demineralized area of a tooth, usually appearing as a chalky, white spot or white line near the gum line. A white spot lesion is considered an early indicator of tooth decay, especially in primary teeth.

Date of Dental Screening: _____

Provider Type*:
☐ DDS ☐ RDH ☐ MD/DO ☐ PA ☐ Nurse *High school screening can only be provided by DDS or RDH.

Provider Name: _____ Provider Signature: _____

Business Address: _____

Business Phone: _____

A screening does not replace an exam by a dentist.
Children should have a complete examination by a dentist at least once a year.

Iowa Department of Public Health, Oral Health Bureau
515-281-3733 • 866-528-4020 • http://www.idph.state.ia.us/hpcdp/oral_health.asp