

# Allen County Non Public School Association

## Grades 1-8 Health Forms 2023-2024

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**All forms are required 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 each year on all students in grades K, 1 and 6. 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 20-34-3-3), 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 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 (this does not include any herbal medications). 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 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.**

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## CHIRP Consent Form

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 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 hereby consent to the release of such information.

I, as a parent/legal guardian to the below stated child, give \_\_\_\_\_ School permission to release in addition to immunization data, the following information concerning my child to the the Indiana State Department of Health's Children and Hoosiers Immunization Registry Program (CHIRP):

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Parent(s)/Guardian(s)

\_\_\_\_\_

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State and Zip Code

\_\_\_\_\_  
Printed Legal Name of Child

\_\_\_\_\_  
Birthdate of Child

Grade \_\_\_\_\_

**PLEASE RETURN AT REGISTRATION OR BEFORE FIRST DAY OF SCHOOL**

(revised ACNPSA 1/2023)

# Allen County Non Public School Association

## HEALTH QUESTIONNAIRE

(Parent/Guardian needs to complete)

### Please Print

Student \_\_\_\_\_ Grade \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_

Father's name \_\_\_\_\_ Mother's name \_\_\_\_\_

Student lives with \_\_\_\_\_

### Health History

Check all that apply to your child

ADD/ADHD (circle)

Allergy (specify)

Seasonal \_\_\_\_\_

Food \_\_\_\_\_

Other \_\_\_\_\_

Asthma

Chickenpox

Diabetes

Chronic Ear Infections

Emotional Disorder

GI/GU Issues

Hearing Impairment

Hepatitis

Measles/Mumps/Rubella

Mononucleosis

Physical Handicaps

Pneumonia

Rheumatic Fever

Scarlet Fever

Seizures

Tuberculosis

Vision Impairment

Whooping Cough

Other \_\_\_\_\_

Other \_\_\_\_\_

Other \_\_\_\_\_

Other \_\_\_\_\_

Any checks made above, please give explanations and dates of diagnosis:

\_\_\_\_\_  
\_\_\_\_\_

Has your child had an infectious/communicable disease other than those listed above? Please explain, giving relevant dates:

\_\_\_\_\_  
\_\_\_\_\_

Does your child require the use of an EPI-PEN for allergic reactions? \_\_\_\_\_

**CONTINUED ON REVERSE**

**Please be specific and include the month/year:**

Severe Illnesses: \_\_\_\_\_

Severe Injuries: (head injury, fractures, etc.): \_\_\_\_\_

Diagnostic Procedures: \_\_\_\_\_

Hospitalizations: \_\_\_\_\_

Surgical 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 condition that should be considered in planning your child's school day:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone # \_\_\_\_\_

Dentist's Name: \_\_\_\_\_ Phone # \_\_\_\_\_

Eye Doctor's 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

# Allen County Non Public School Association

## PHYSICIAN CERTIFICATE OF EXAMINATION FORM

(To be completed by your child's physician)

Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Allergies \_\_\_\_\_

### Current Medications

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 \_\_\_\_\_

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

Yes \_\_\_\_\_ No \_\_\_\_\_ If no, please explain \_\_\_\_\_

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

CONTINUED ON REVERSE

# 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

**Kindergarten –5<sup>th</sup> Grades**

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

**6<sup>th</sup> - 8<sup>th</sup> 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**