# Kindergarten Health Packet

**Contents:**

- Important Information for Kindergarten
- General Health Information
- Health Screening Information & Required Forms
    1. **CHIRP Consent Form** – Must be completed, signed, and returned to the school office by August 1, 2023
    2. **Health Questionnaire** – Must be completed and returned to the school by August 1, 2023
    3. **Physician Certificate of Examination Form** – Must be completed by the student's physician and returned to the school by August 1, 2023
    4. **Immunization History** – Please have the student's physician attach a copy of the FULL immunization record and return the form to the school by August 1, 2023
    5. **Vision Examination Form** – Must be completed by examining eye doctor and returned to the school by August 1, 2023
    6. **Certificate of Dental Examination Form** – Must be completed by the student's dentist and returned to the school by August 1, 2023

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**
**BEFORE the first day of school**

**A current copy of immunization records must be on file for all students**

# Important Information for Kindergarten Entrance

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, Physician Certificate of Examination, Immunization History, CHIRP Consent, Vision Examination Form, and Certificate of Dental Examination Form. Please send all completed forms to the office – Attention School Nurse.

**Physician Certificate of Examination:** All kindergarten students are required to have a recent physical signed by their physician along with "Health Questionnaire" form submitted to the school office no later than the first day of school.

**Required 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 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). Remember to provide the school with documentation of all shots received from infancy through the current date.

**CHIRP:** As required by IC 20-34-4-6, each school must report immunizations to the State Department of Health. This report is currently done online through CHIRP (Children and Hoosier Immunization Registry Program). We will need a consent signed for each child in order to report this information to the state. Once signed, this consent applies to all years your student(s) attend Saint Elizabeth Ann Seton Catholic School. This form needs to be submitted to the school office no later than the first day of school.

**Required free vision screening for all kindergarteners:** IC 20-34-3-12 **requires all kindergarten or first graders to have an MCT exam done by either an optometrist or ophthalmologist**. We choose kindergarten to be done. Your pediatrician CANNOT perform this exam. 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 child. If you prefer to use your own optometrist or ophthalmologist, please take this form to them to fill out after your child's exam. It is so important that your child be screened for any vision problems at an early age to detect and correct any abnormalities that may exist.

******This exam needs to be done before the first day of school******

**Required Certificate of Dental Examination Form:** Good dental health is important. You will find a Certificate of Dental Examination form in this packet that should be completed by your child's dentist as proof of them receiving routine dental care. This is a one-time form for Kindergarten students.

**Does your child have Asthma, Food Allergies, Diabetes, or a history of Seizures?** If yes, please contact the school office as additional health forms must be completed and on file.

# General Health Information

**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. To help establish a regular bedtime, it is recommended to turn off TV and electronics at least 30 minutes prior to bed. This is a great time to be reading to your 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 has a fever and **must stay home for at least 24 hours** (free of fever 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 should be brought to school by an adult in their original package and accompanied by a medication consent form that can be obtained from 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. Please see the school office should you need such forms. **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 "Medication Consent" form.

# 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

# HEALTH QUESTIONNAIRE

**Parent / Guardian to complete**

*This is not an annual form. 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 check) | | | **Disease/Condition** (please check) | | |
|---|---|---|---|---|---|
| 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' checked 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: _____



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

# 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

**Page 2 of 2**

**Both sides must be completed**

# 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)**

# 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 a 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. **CALL for an appointment no later than JULY 1st** and 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

- Dr. Steven Bennett 490-1060
  1850 East Dupont Rd. Fort Wayne, IN

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

- Hockemeyer Family Eye Care:
  Dr. Troy Hockemeyer 493-1505
  Dr. Andrew Hoffman
  1010 Boulder Ridge Trail New Haven, IN

- Dr. Thomas Zachman 432-1231
  7625 W. Jefferson Blvd. Ft 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 1/23)

# Kindergarten 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 1/23)

# 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_____

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_____

_____

**Recommendations**_____

_____

Print/Stamp Dentist's Name

_____

_____

Date: _____

Phone Number: _____