

**St. Joseph School** Hessen Cassel

11521 Old U.S. 27 South • Fort Wayne, Indiana 46816 • 260-639-3580

# Kindergarten Health Forms 2021-2022

## **Contents:**

Important Information for Kindergarten  
General Health Information

**Required Health Screening Forms:** All forms must be on file prior to the first day of school

- CHIRP Consent Form
- Copy of Immunization Records- See attached for specific requirements
- Health Questionnaire
- Vision Screening Form
- Dental Exam Form
- Physician Certificate of Examination Form

**All forms should be returned to the school office NO LATER than  
the first day of school**

## 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.

### **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 copy of your child's immunizations from your their 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 for the correct forms).

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.

### **Required vision screening for all Kindergarteners (FREE):**

Indiana Code (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. This required exam **CANNOT** be done by a pediatrician. **To take advantage of a FREE vision screening for your child, please check the back side of the "Pre-Kindergarten Vision Examination" form for a list of local optometrists who have agreed to provide this service at no cost for your child.** To take advantage of the free screening, it must be scheduled BEFORE JULY 1<sup>st</sup>. 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.**

**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. Please inform the school if any changes to your child's health status change throughout the year.

**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 by our school nurse through CHIRP (Children and Hoosier Immunization Registry Program). Attached you will find a consent to sign which allows our school to report this immunization information. Once signed, this consent applies to all years your student(s) attend Saint Joseph Hessen Cassel School.

**Dental:** All students are strongly encouraged to visit their dentist regularly and have the "Certificate of Dental Examination" form completed prior to their first day of Kindergarten. While we do not screen for dental issues, it is an important part of our general health and well-being.

**PLEASE RETURN ALL PAPERWORK TO THE SCHOOL OFFICE AS SOON AS IT IS COMPLETED BUT NO LATER THAN THE FIRST DAY OF SCHOOL.**

# 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. Establish a regular bedtime. Turn off the TV and videos and read a book before bed!

## 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. **Unfortunately, if this is not done, you will receive a letter excluding your child from school until the immunizations have been obtained and proper paperwork has been filed.**

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). Please contact the school office if you need either of these forms.

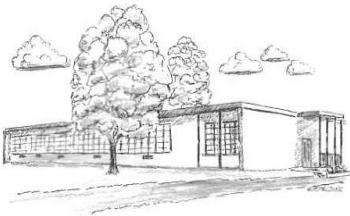
## When your child is ill:

Children with a 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 need to be brought to school by an adult in their original package and accompanied by the medication consent form found in 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 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). 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 "Medication Consent" form.

★ Medication consent forms, asthma and allergy action plans, diabetic care plans, and additional health information and handouts are also available on our school website under School Tab – Student Health



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## 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 permission to Saint Joseph Hessen Cassel School to release such information

I DO NOT give permission to Saint Joseph Hessen Cassel 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 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 child care 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

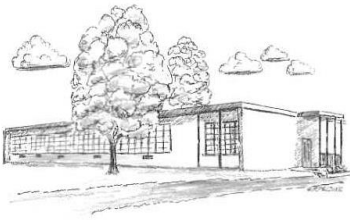
\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Parent or Guardian

\_\_\_\_\_  
Telephone #

\_\_\_\_\_  
Address

Once signed, this form will apply to all years your student is attending Saint Joseph Hessen Cassel School



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## 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 circle)

Seasonal allergies Yes No

\*Food allergy Yes No

\*Asthma Yes No

ADD/ADHD Yes No

Chicken Pox Yes No

\*Diabetes Yes No

Diphtheria Yes No

Ears/Infections Yes No

Epilepsy Yes No

\*Seizures Yes No

Handicaps/Impairments Yes No

(Hearing/Physical/Vision)

**Disease/Condition** (please circle)

Measles/Mumps/Rubella Yes No

Pneumonia Yes No

Heart Murmur Yes No

Emotional disorder Yes No

Bowel or bladder issues Yes No

Mononucleosis Yes No

Hepatitis Yes No

Tuberculosis Yes No

Whooping Cough Yes No

Other Yes No

*\* Additional forms required- see school nurse*

For any 'yes' circled above, please give explanations and dates of diagnoses.

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

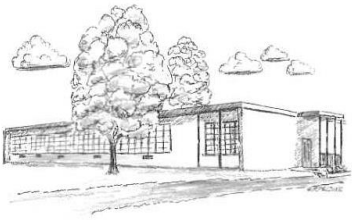
Has your child had an infectious/communicable disease other than those listed above? Yes No

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: \_\_\_\_\_



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**Please list any of the following with month/year:**

Operations: \_\_\_\_\_

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

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

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

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: \_\_\_\_\_

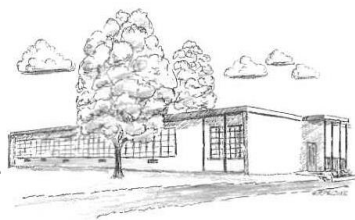
Dentist Name: \_\_\_\_\_ Phone: \_\_\_\_\_

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



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## Kindergarten Vision Examination

Name \_\_\_\_\_ Birthdate \_\_\_\_\_  
(Last) (First) (MI)

Address \_\_\_\_\_

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

### Examiner's Report

#### VISUAL ACUITY

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

<b>REFRACTIVE EYE EXAM</b>	<b>PASS</b>	<b>FAIL</b>
<b>OCULAR HEALTH</b>	<b>PASS</b>	<b>FAIL</b>
<b>EYE BINOCULAR COORDINATION EXAM</b>	<b>PASS</b>	<b>FAIL</b>

Has the child been prescribed eyeglasses or contacts 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 Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_

Stamped or Printed Name, Address and Phone Number of Examining Doctor:

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



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### **FREE Kindergarten Vision Screening**

All students going into Kindergarten **MUST** have an MCT eye exam done prior to entering Kg. Although you can use your own eye doctor, the following Optometrists have volunteered to provide a **FREE** pre-kindergarten screening in their offices. I encourage you all to take advantage of this rare FREE preventative health opportunity. This required exam cannot be done by your pediatrician and **MUST** be completed before the first day of school.

#### **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 1** and tell them that your appointment is for pre-kindergarten screening.
3. Be sure to take this pre-kindergarten vision screening report 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

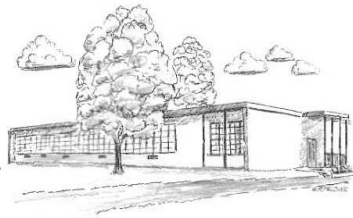
Dr. Troy Hockemeyer 493-1505  
Dr. Andrew Hoffman  
1010 Boulder Ridge Trail New Haven, IN

Dr. Thomas Zachman 432-1231  
7625 W. Jefferson Blvd. Ft Wayne, IN

We are most appreciative to the above optometrists for their FREE services to the Allen County Non-Public Schools!

**PLEASE** give them a word of thanks for taking time to give back to our community!





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**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**

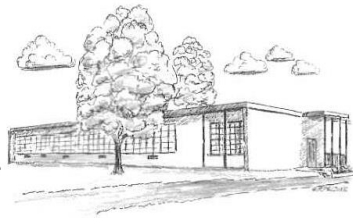
- 1. Cavities \_\_\_\_\_
- 2. Malocclusion \_\_\_\_\_
- 3. Soft Tissue \_\_\_\_\_
- 4. Oral Hygiene \_\_\_\_\_
- 5. Fluoride \_\_\_\_\_
- 6. Sealant \_\_\_\_\_

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

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



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**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 \_\_\_\_/\_\_\_\_/\_\_\_\_

Medication Allergies \_\_\_\_\_

**Current Medications:** (list name, dosage, and time)

1. \_\_\_\_\_ Dosage \_\_\_\_\_ Time \_\_\_\_\_

2. \_\_\_\_\_ Dosage \_\_\_\_\_ Time \_\_\_\_\_

3. \_\_\_\_\_ Dosage \_\_\_\_\_ Time \_\_\_\_\_

**Height** \_\_\_\_\_ **Weight** \_\_\_\_\_ **B/P** \_\_\_\_\_

**Eyes:** \_\_\_\_\_

**Ears:** \_\_\_\_\_

**Nose:** \_\_\_\_\_

**Throat** \_\_\_\_\_

**Chest:** \_\_\_\_\_

**Heart:** \_\_\_\_\_

**Hernia:** \_\_\_\_\_

**Extremities:** \_\_\_\_\_

**Posture/Scoliosis:** \_\_\_\_\_

**Lead level** (if indicated) \_\_\_\_\_

**Sickle Cell**(if indicated) \_\_\_\_\_

**Hemoglobin** (if indicated) \_\_\_\_\_

**Hematocrit** (if indicated) \_\_\_\_\_

**Urinalysis** (if indicated) \_\_\_\_\_

**Tuberculin test:** (if indicated)

Results: \_\_\_\_\_ Date: \_\_\_\_\_

<p><b>Check only if applies:</b>  <i>(If checked additional forms with MD signatures required)</i></p> <p><input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> Food Allergies</p> <p><input type="checkbox"/> Need for Epi-Pen</p> <p><input type="checkbox"/> Heart Condition</p> <p><input type="checkbox"/> Diabetes</p>
--

List Abnormal Results: \_\_\_\_\_

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

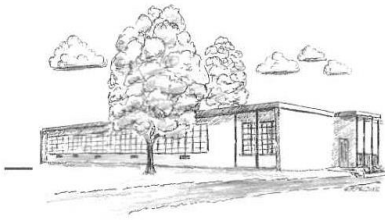
Yes \_\_\_\_\_ No \_\_\_\_\_ If no, please explain \_\_\_\_\_

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:

**Kindergarten - 5<sup>th</sup> Grade**

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

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

Previous listed plus additional Tdap (Tetanus, Diphtheria & Pertussis) (1) and MCV (Meningococcal) (1)

**All minimum ages and intervals for each vaccination as specified in the CDC guidelines must be followed to be considered valid.**

**Students will be asked to return to doctor's office if intervals and minimum ages are not met.**

\_\_\_\_\_  
**Printed or Stamped name of the Physician completing this form**

\_\_\_\_\_  
**Physician's signature**

\_\_\_\_\_  
**Date**

