

Waynesville Elementary School

KINDERGARTEN REGISTRATION

2009-10

Health Packet

1. **Dear Parents** (*regarding immunizations*) this is for your information.
2. **Kindergarten Medical Needs Questionnaire** - Please complete and return this form on August 10th.
3. **Health History Questionnaire** - Please complete and return this form on August 10th.
4. **Health History** - Please complete and return this form on August 10th.
5. **Dentist Report** - Please have your dentist complete this form and return it the week of August 10th. No faxed copies please.
6. **Physician Report** - Please have your doctor complete this form and return it the week of August 10th. No faxed copies please.
7. **Vision Report** - Please have your doctor complete this form and return it the week of August 10th. No faxed copies please.

WAYNE LOCAL SCHOOLS

Denise Richmond, R.N., School Nurse

Immunizations Summary for Child Care, Head Start, Pre-School and School Attendance

VACCINES	FALL 2009 IMMUNIZATIONS FOR CHILD CARE/HEAD START AND PRE- SCHOOL ATTENDANCE	FALL 2009 IMMUNIZATIONS FOR SCHOOL ATTENDANCE
DTaP/DTP/DT /Td Diphtheria, Tetanus, Pertussis	4 doses of DTaP, DTP, or DT or any combination.	Kindergarten 5 doses of DTaP, DTP, or DT, or any combination, if the fourth dose was administered prior to the 4 th birthday Grades 1-12 * 3-4 doses of DTaP, DTP, DT or Td or any combination.
POLIO	3 doses of OPV or IPV or any combination of OPV or IPV.	K-12 4 doses if a combination of OPV or IPV was administered. 4 doses of all OPV or all IPV is required if the third dose of either vaccine was administered prior to the 4 th birthday.
MMR Measles, Mumps, Rubella	1 dose of MMR administered on or after the first birthday	K-12 2 doses of MMR. Dose 1 must be administered on or after the first birthday. The second dose must be administered at least 28 days after dose 1.
Hib Haemophilus Influenzae Type b	3 or 4 doses depending on the vaccine type and the age when the child began the 1 st dose and the last dose is after 12 months or 1 dose if given on or after 15 months of age	None
HEP B Hepatitis B	3 doses of Hepatitis B	K-10 3 doses of Hepatitis B. The second dose must be administered at least 28 days after the first dose. The third dose must be given at least 16 weeks after the first dose and at least 8 weeks after the second dose. The last dose in the series (third or fourth dose), must not be administered before age 24 weeks. Grades 11-12 Hepatitis B not required
Varicella (Chickenpox)	None	K-3 1 dose of varicella vaccine must be administered on or after the first birthday

*A student who is age 7 or older, and who received Td or Tdap vaccine as the third part of the immunization series, shall not be required to receive further doses of diphtheria, tetanus, or pertussis vaccine.

NOTES:

- The 4 day "grace" period applies to all age and interval minimums. If MMR and varicella have not been given on the same day they must be separated by 28 days with no grace period.
- The 5th dose of DTaP, DTP or DT, and 4th dose of Polio will not be required until Kindergarten. At Kindergarten, these doses will be required if the 4th DTaP and 3rd Polio were administered prior to the 4th birthday.
- The Hepatitis B and Varicella requirements will be progressive.
- Only full doses of vaccine using proper intervals shall be counted as valid doses.
- For additional information please refer to the Ohio Administrative Code 5101:2-12-37 for Child Care, Head Start, Pre-School and the Ohio Revised Code 3313.67 and 3313.671 for School Attendance. These documents require certain immunizations as well as provides for certain exemptions to immunizations.

Wayne Local Schools

659 Dayton Road

Waynesville, Ohio 45068

2009-10 MEDICAL NEEDS QUESTIONNAIRE

**PLEASE COMPLETE CONFIDENTIAL INFORMATION
TO BE SHARED WITH TEACHING STAFF**

Student's Name: _____

1. Does your child have asthma or Reactive Airway Disease as diagnosed by a physician? _____.
If yes, please fill out an ASTHMA QUESTIONNAIRE.

2. Has your child had any allergic reactions to medications, food, insects, tape, latex, etc. _____.
If yes, please list all allergies and treatment required. _____

3. Has your child been diagnosed with ADD or ADHD by your physician?
If yes, which type? ____ ADD or ____ ADHD **Please list all medications** taken for the condition.

(Medication, Amount, and Time of Administration)*

4. Does your child have a seizure disorder as diagnosed by a physician? _____.
If yes, please list all medications taken for this condition. _____

(Medication, Amount, and Time of Administration)*

5. Has your child been identified as having a bleeding tendency? _____.

6. Does your child have diabetes? _____
If yes, please list all medications (insulin and pills) taken for this condition. _____

(Medication, Amount, and Time of Administration)*

7. Does your child wear glasses? _____ Contacts? _____ Other eye conditions _____
If yes, is the correction for near or distance vision difficulties. _____

8. Has your child had any major illnesses, hospitalizations or surgeries?
If yes, please explain and give dates. _____

9. Please list any other health concerns you have for your child:

Parent's signature indicates permission to share this medical history information with teaching staff:

Parent's Signature: _____ Date: _____

***If medication needs to be given at school, please complete a Medication Administration Form.**

Wayne Local Schools

Denise Richmond, R.N., School Nurse

Health History Questionnaire New Students – 2009-10

Child's Name _____ Grade: _____

Dear Parents:

Please complete the following questionnaire concerning your child's health. If you answer **YES** to any of the following questions, please **REQUEST** the appropriate health form(s) from the building secretary.

- 1) Does your child need any medication given during school hours? ___ Yes ___ No
If **YES**, please request the following forms:
 - Medication Administration Request Form
 - Medication Administration Policy

- 2) Does your child have asthma or other respiratory conditions? ___ Yes ___ No
If **YES**, please request the following forms:
 - Asthma Questionnaire
 - Medication Administration Policy
 - Medication Administration Request Form **OR**
 - Self-Administration For Asthma Inhalers

- 3) Is your child allergic to insect stings? ___ Yes ___ No
If **YES**, please request the following forms:
 - Insect Sting Questionnaire
 - Medication Administration Policy
 - Medication Administration Request Form **OR**
 - Self-Administration For Epi Pen

- 4) Is your child allergic to any foods, latex, etc. that requires medication to be given in the event of an allergic reaction? ___ Yes ___ No
If **YES**, please request the following forms:
 - Allergy Questionnaire
 - Medication Administration Policy
 - Medication Administration Request Form **OR**
 - Self-Administration For Epi Pen

All new students – please state all health concerns on the Annual Update Form. Please request the Annual Update Form if it is not in your registration packet. Please return all form(s) to Denise Richmond, School Nurse, as soon as possible so we may be aware of your child's health problems.

Denise Richmond, R.N., School Nurse

Ohio Department of Health • School and Adolescent Health Health History

Student's name	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth / /
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Family Health History Please list allergies, heart problems, diabetes, cancer or other serious health conditions.

Father
Mother
Brothers and Sisters

Birth and Developmental History No unusual birth or developmental history

Did the mother have any unusual physical or emotional illness during this pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No
Was infant born full term? <input type="checkbox"/> Yes <input type="checkbox"/> No Did the infant have any sickness or problems? <input type="checkbox"/> Yes <input type="checkbox"/> No
Briefly explain illness or problems. _____
How does the child's development compare to other children, such as his or her brothers/sisters or playmates? <input type="checkbox"/> About the same <input type="checkbox"/> Delayed <input type="checkbox"/> Advanced

Student Health Conditions

<input type="checkbox"/> YES , my child receives regular medical/health care for the following conditions:			<input type="checkbox"/> NO medical conditions		
<input type="checkbox"/> Allergies	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Seizure disorder			
<input type="checkbox"/> Asthma	<input type="checkbox"/> Depression	<input type="checkbox"/> Sickle cell anemia			
<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Ear problem/hearing difficulty	<input type="checkbox"/> Skin conditions			
<input type="checkbox"/> Autism	<input type="checkbox"/> Emotional concerns	<input type="checkbox"/> Speech problems			
<input type="checkbox"/> Behavior concerns	<input type="checkbox"/> Headaches	<input type="checkbox"/> Traumatic brain injury			
<input type="checkbox"/> Birth/congenital malformations	<input type="checkbox"/> Heart problems	<input type="checkbox"/> Vision problems (glasses, contacts)			
<input type="checkbox"/> Bone/muscle/joint problems	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Other _____			
<input type="checkbox"/> Blood problems	<input type="checkbox"/> Juvenile arthritis	<input type="checkbox"/> Other _____			
<input type="checkbox"/> Bowel/bladder problems	<input type="checkbox"/> Lead poisoning	<input type="checkbox"/> Other _____			
<input type="checkbox"/> Cancer	<input type="checkbox"/> Migraines	<input type="checkbox"/> Other _____			
<input type="checkbox"/> Cystic fibrosis	<input type="checkbox"/> Neuromuscular disorder	<input type="checkbox"/> Other _____			

Please explain any conditions above or any reasons for hospitalizations.

Please indicate any allergies your child may have.

Allergy type	Reaction	School restrictions or recommended actions
<input type="checkbox"/> Bee/Insect		
<input type="checkbox"/> Food		
<input type="checkbox"/> Medication		
<input type="checkbox"/> Other		

Health History continued

Please list any prescription and over the counter medication that your child takes on a regular basis.

Medication and dose	Time	Reason

Do any health and/or medical conditions require school restrictions, modifications, and/or intervention?

Yes No If YES, please explain.

Does the student require any special procedures and/or treatments for their health condition(s)?

Yes No If YES, please explain.

Please indicate any other information about your child's health or development that you think would be helpful for the school to know.

Form completed by	Relationship to student	Date / /
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WAYNE LOCAL SCHOOLS

Denise Richmond, R.N., School Nurse

DENTIST REPORT

Student's name	Date of birth / /
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The following services have been performed (please check all that apply)

<input type="checkbox"/> Examination	<input type="checkbox"/> Fluoride application	<input type="checkbox"/> Oral prophylaxis (cleaning)	<input type="checkbox"/> Prescription for fluoride supplement
<input type="checkbox"/> Orthodontic assessment	<input type="checkbox"/> Radiographs	<input type="checkbox"/> Dental sealant	<input type="checkbox"/> Treatment (restoration, pulp therapy)
<input type="checkbox"/> Other _____			

The following oral hygiene instruction was provided (please check all that apply)

<input type="checkbox"/> Toothbrushing	<input type="checkbox"/> Flossing	<input type="checkbox"/> Dietary counseling	<input type="checkbox"/> Use of fluoride mouthrinse
<input type="checkbox"/> Other _____			

The following statements are applicable (please check all that apply)

<input type="checkbox"/> All necessary preventive services have been performed. (Fluoride treatment, prophylaxis)
<input type="checkbox"/> No restorative services are required at this time.
<input type="checkbox"/> Further treatment is indicated. (See comments)
<input type="checkbox"/> Further appointments have been arranged. (Orthodontic, restorative)
<input type="checkbox"/> Routine recall visits recommended.

Comments

Dentist's signature	Print name	Phone ()
Address		Date / /
City	State	ZIP

WE MUST HAVE THE ORIGINAL FORM - NO FAXED COPIES

Please return this form to the Elementary School Office as soon as possible.

Denise Richmond, R.N.
School Nurse
Wayne Local Schools
659 Dayton Road
Waynesville, OH 45068
513-897-2761 or 513-897-4350

**Waynesville Elementary School
659 Dayton Road
Waynesville, Ohio 45068**

PHYSICIAN REPORT

Student's Last Name First Middle Date of Birth

PHYSICAL EXAMINATION - THIS SECTION MUST BE FILLED IN AND SIGNED BY THE PHYSICIAN

Date: _____ Age: _____ Height: _____ Weight: _____

I. GENERAL APPEARANCE AND NUTRITIONAL STATE

Posture: _____	Lungs: _____
Skin: _____	Abdomen: _____
Eyes: _____	Genitalia: _____
Ears: _____	Hernia: _____
Nose: _____	Neurological: _____
Throat (tonsils): _____	Emotional: _____
Mouth (teeth) etc. _____	Blood Pressure: _____
Neck: _____	Hemoglobin: (optional) _____
Heart: _____	Urinalysis: (optional) _____

MAY CARRY FULL PHYSICAL EDUCATIONAL PROGRAM? YES NO

RESTRICTIONS, PLEASE EXPLAIN _____

What medication, if any, is child taking? _____

II. IMMUNIZATIONS

	Date	Date	Date	Date	Date
DTaP DPT or DT	_____	_____	_____	_____	_____
DT/Td	_____	_____	_____	_____	_____
POLIO	_____	_____	_____	_____	_____
MMR	_____	_____	_____	_____	_____
HEPATITIS B	_____	_____	_____	_____	_____
VARICELLA	_____	_____	_____	_____	_____
HIB (prior to age 5 only)	_____	_____	_____	_____	_____
TUBERCULLIN TEST (optional)	_____	Negative or Positive _____			

**III. SPECIAL TESTS
(at Doctor's Discretion)**

PHYSICIAN'S SIGNATURE _____ DATE _____

WE MUST HAVE THE ORIGINAL FORM - NO FAXED COPIES

Please return this form to the Elementary School Office the week of:
August 10, 2009

It is important that we complete your child's medical file before school starts.

Thank you for your cooperation.

Denise Richmond, R.N.
School Nurse
Wayne Local Schools
659 Dayton Road
Waynesville, OH 45068

513-897-2761 or 513-897-4350

WAYNESVILLE VISION EXAM

Please complete the IDENTIFYING INFORMATION and RECORDS

IDENTIFYING INFORMATION

Student Name: _____

Parent/Guardian Name: _____

CASE HISTORY

Ocular History: Normal _____ or Positive for: _____

Medical History: Normal _____ or Positive for: _____

Drug Allergies: NKDA _____ or Allergic to: _____

Family Ocular and Medical History:

_____ Amblyopia _____ Strabismus _____ Glaucoma _____ Diabetes

Other: _____

Other Pertinent Information: _____

Cycloplegic refraction performed? _____ Yes _____ No

	<u>OD</u>	<u>OS</u>
Unaided Acuity	20/_____	20/_____
Current Prescription Acuity	20/_____	20/_____
New Prescription Acuity	20/_____	20/_____

	<u>Normal</u>	<u>Abnormal</u>	<u>Not Tested</u>
External Exam (eye and adnexa)	_____	_____	_____
Internal Exam (media, lens, fundus, etc.)	_____	_____	_____
Neurological Integrity (pupils)	_____	_____	_____
Stereopsis	_____	_____	_____
Accommodation and Convergence	_____	_____	_____
Color Vision	_____	_____	_____
Cover Test (distance)	_____	_____	_____
Cover Test (near)	_____	_____	_____

DIAGNOSIS

_____ Normal _____ Myopia _____ Hyperopia _____ Astigmatism _____ Strabismus _____ Amblyopia

Other: _____

RECOMMENDATIONS

Glasses prescribed: _____ Yes _____ No

Other: _____

Return for next exam: _____

Signed: _____ Date: _____

(Optometrist / Ophthalmologist)

Address: _____ Telephone: _____

City/State/Zip: _____

VISION REQUIREMENT

Vision screening programs are intended to help identify children with eye or vision problems that threaten sight or impair their ability to develop and learn normally. However, vision screenings are a limited process and can not be used to diagnose an eye or vision problem, but rather to indicate a potential need for future evaluation.

Comprehensive vision examination can only be conducted by an eye care professional with the specialized training needed to make a definite diagnosis and prescribe treatment.

It is for the above reasons that I am requesting that every child, before entering Waynesville Elementary, have a comprehensive eye exam done by an optometrist/ ophthalmologist. Please have the reverse form completed and returned the week of August 10th.

Thank you,

Denise Richmond, R.N.
School Nurse

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