Medical Information

Any attached forms are not valid unless completed by someone at your child's doctor/dentist office and must be returned to school prior to the first day of school.

COMMONWEALTH OF KENTUCKY

IMMUNIZATION CERTIFICATE

(Required for each child enrolled in day care center, certified family child care home, other licensed facility which cares for children, preschool programs, and public and private primary and secondary schools.)

Name of Child: ____ Birthdate: _____________
(Last) (First) (Middle)

Name of Parent of Guardian: ____

Address: ____
(Street) (City) (State) (Zip code)

DATES IMMUNIZATIONS WERE ADMINISTERED (Month/Day/Year)

Diphtheria, Tetanus, Pertussis* **#1**___/___/___ **#2** ___/___/___ **#3** ___/___/___ **#4** ___/___/___ **#5** ___/___/___

Hib** **#1** ___/___/___ **#2** ___/___/___ **#3** ___/___/___ **#4** ___/___/___

PCV (Pneumococcal) **#1** ___/___/___ **#2** ___/___/___ **#3** ___/___/___ **#4** ___/___/___

Polio **#1** ___/___/___ **#2** ___/___/___ **#3** ___/___/___ **#4** ___/___/___

Hepatitis B*** **#1** ___/___/___ **#2** ___/___/___ **#3** ___/___/___ **or Adult dose: #1** ___/___/___ **#2** ___/___/___

MMR (Measles, Mumps, Rubella) **#1** ___/___/___ **#2** ___/___/___

Varicella **#1** ___/___/___ **#2** ___/___/___ **or child has had chickenpox or zoster disease (X)** ____

Tdap **#1** ___/___/___ **or Td #1** ___/___/___ **Meningococcal** **#1** ___/___/___

*DTaP, DTP, or DT. **Hib not required at 5 years of age or more. ***Alternative two dose series of approved adult hepatitis B vaccine for adolescents 11 through 15 years of age.

This child is current for immunizations until ___/___/___, (14 days after the next shot is due) after which this certificate is no longer valid, and a new certificate must be obtained.

I CERTIFY THAT THE ABOVE NAMED CHILD HAS RECEIVED IMMUNIZATIONS AS STIPULATED ABOVE.

____ _______________
(Signature of physician, APRN, PA, pharmacist, LHD administrator, or nurse designee) (Date)

____
(Name of Office or Licensed Healthcare Facility)

This certificate should be presented to the school or facility in which the child intends to enroll and should be retained by the school or facility and filed with the child's health record.

PREVENTATIVE HEALTH CARE EXAMINATION FORM

All local boards of education shall require a preventative health care examination of each child first entering a Kentucky public school within a period of twelve (12) months prior to initial admission to school and within one (1) year prior to entry to sixth grade. Local school boards may extend this time not to exceed two (2) months. (702 KAR 1:160)

PLEASE COMPLETE THE INDENTIFYING INFORMATION AND RECORDS

IDENTIFYING INFORMATION

Student Name: ______________________ **Gender:** M F **Grade:** ________

Date of Birth: ____________ **Age:** ____ yrs ____ months **Preferred Language:** ____________

Parent or Guardian Name: ______________________________

RECORD OF IMMUNIZATIONS TO BE REPORTED ON IMMUNIZATION CERTIFICATE FORM, EPID 230.

MEDICAL HISTORY

Allergies: ______________________________

Current Prescribed Medications to be taken daily at school: ______________________________

Significant Historical Information: ______________________________

SCREENING RESULTS:

Height: ____ ft ____ inches ____ **Weight** ____ **BMI:** ____ **BMI%** ____ **B/P:** ____

Vision	Right 20/____	Passed ☐ Failed ☐ Referred ☐	Hearing – Right	Passed ☐	Failed ☐	Referred ☐
	Left 20/____		Hearing - Left	Passed ☐	Failed ☐	Referred ☐

Optional: **Hct/HGB:** ________ **Lead:** ________ **Urinalysis:** ________

Gross dental (teeth and gums)	☐ Normal	☐ Abnormal ________	Refer/Tx: ________
Head/scalp/skin	☐ Normal	☐ Abnormal ________	Refer/Tx: ________
Eyes/Ears/Nose/Throat	☐ Normal	☐ Abnormal ________	Refer/Tx: ________
Chest/Lungs/Heart	☐ Normal	☐ Abnormal ________	Refer/Tx: ________
Abdomen	☐ Normal	☐ Abnormal ________	Refer/Tx: ________
Scoliosis assessment	☐ Normal	☐ Abnormal ________	Refer/Tx: ________

(Over)

This child has the following problems that may impact the educational experience:

☐ Vision ☐ Hearing ☐ Speech/Language ☐ Physical ☐ Social/Behavioral ☐ Cognitive

Specify: ______________________________

____

☐ **This child has a health condition that may require emergency action at school, e.g. seizures, allergies. Specify below.**

____

Recommendations (Attach additional sheet if necessary): ______________________________

____

(Please Check One)

☐ **This child may participate fully in school activities including physical education.**

☐ **This child may participate in school activities including physical education with the following restriction/adaptation.**

(Specify reason and restriction) ______________________________

____

ANTICIPATORY GUIDELINES

Discussed and/or handout given

☐ SCHOOL READINESS
- Establish routines
- After-school care/activities
- Friends
- Bullying
- Communicate with teachers

☐ MENTAL HEALTH
- Family time
- Anger management
- Discipline for teaching not punishment
- Limit TV, computer

☐ NUTRITION AND PHYSICAL ACTIVITY
- Healthy weight
- Well-balanced diet, including breakfast
- Fruits, vegetables, whole grains, dairy
- 60 minutes of exercise/day

☐ ORAL HEALTH
- Regular dentist visits
- Brushing/Flossing
- Fluoride

☐ SAFETY
- Sexual safety
- Pedestrian safety
- Safety helmets
- Swimming safety
- Fire escape plan
- Smoke/carbon monoxide detectors
- Guns
- Sun
- Appropriately restrained in all vehicles

Additional comments or recommendations: ______________________________

____

____

____

____

____

Signed: ______________________________ **Date:** ______________________________

Physician/APRN/PA/EPSDT Provider

Address: ______________________________ **Telephone:** ______________________________

Garrard County Preschool/Early Education Program
Kentucky River Foothills Head Start/Early Head Start

Lead Screening Information

Child's Name____________________________________ Date of Birth_____________

Dear Health Care Provider,

The Center for Medicare and Medicaid Services require Primary Care Providers to perform a Blood Lead Level test on children at the ages of 12 and 24 months of age. Children between the ages of 36 and 72 months must have a Blood Lead Level test if they have not previously had one. **This is a requirement for children in Early Head Start and Head Start Programs.**

Please indicate the results of the most recent Blood Lead Level screening below and return this form to the parent or fax it to the Head Start/Preschool location at (606)256-1027. **In order to meet Head Start requirements, this test cannot be dated prior to the child's 2nd birthday.** If you have any questions, please call me at (606)256-8301.

Sincerely,

Dreama Roberts

Dreama Roberts

Child's Name____________________________________ DOB__________________

Blood Lead Level Tested? Yes No Date of Test______________________________

Results/Comments____

Provider's Name____________________________________ Phone_________________

Thank you for your continued support serving the health care needs of our children.

OAS/DSS **Kentucky Dental Screening/Examination Form for School Entry** KDESHS005

Kentucky law, KRS 156.160(i), requires proof of a dental screening or examination by a dentist, dental hygienist, physician, registered nurse, advanced registered nurse practitioner, or physician assistant. This evidence shall be presented to the school no later than January 1 of the first year that a five (5) or six (6) year old is enrolled in public school.

Student Name: ______________________________
Last First Middle

Birth date: _____/_____/_____ Gender: ☐ 0 Male ☐ 1 Female

Parent or Guardian: ______________________________
Name Relationship

Address: ____________________ City: ____________________

Phone Number: ____________________ School: ____________________

Date of Exam/Screening _____/_____/_____

Test Type (check one)

☐ Screening

☐ Exam

Screener's Name: ____________________

Screener's Address: ____________________

____

Phone Number: ____________________ Screening Date: __________

Screener's Signature: ____________________

Professional affiliation: (Please check one)

☐ Dentist ☐ Dental Hygienist

☐ Physician Assistant ☐ Registered Nurse with training

☐ APRN ☐ Physician

Untreated Decay: (Check one)

☐ 0 No untreated cavities

☐ 1 Untreated cavities

Treated Decay: (Check one)

☐ 0 No treated cavities

☐ 1 Treated cavities

Pattern of Early Childhood Cavities: (Check one)

☐ 0 No Early Childhood Cavities

☐ 1 Early Childhood Cavities Present

Treatment Urgency: (Check one)

☐ 0 No obvious problem

☐ 1 Early dental care needed

☐ 2 Referral for Urgent Care
NOTE: Comment required if marked.

Comments:

OH-12

3/16/2015

Kentucky Eye Examination Form for School Entry

KRS 156.160 (1) (g) requires proof of a vision examination by an optometrist or ophthalmologist. This evidence shall be submitted to the school no later than January 1 of the first year that a three (3), four (4), five (5) or six (6) year old child is enrolled in public school, public preschool, or Head Start program.

PLEASE COMPLETE THE IDENTIFYING INFORMATION

Date of student's enrollment: ____________ **Date of Vision Examination:** ____________

IDENTIFYING INFORMATION

Student Name: ____________

Date of Birth: ____________

Parent or Guardian Name: ____________

CASE HISTORY

Date of Exam: ____________

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: ____________

Refraction with cycloplegic? (Please indicate one.) ☐ YES ☐ NO

	OD	OS
Unaided Acuity	20/	20/
Best Corrected Acuity	20/	20/

Type of Examination	Normal	Abnormal	Notable to Assess
External Exam (eye and adnexa)			
Internal Exam (media, lens, fundus, etc)			
Neurological Integrity (pupils)			
Binocular Function (stereopsis)			
Accommodation and convergence			
Color Vision			

Diagnosis:

☐ Normal ☐ Myopia ☐ Hyperopia ☐ Astigmatism ☐ Strabismus ☐ Amblyopia

Other: ____________

Recommendations:

1 Glasses prescribed: ☐ YES ☐ NO
2 ____________
3 ____________

Age appropriate and suggested anticipatory guidance (health assessments):

- ☐ Educate (parents/patients) about eye/vision disorders and needed vision care
- ☐ Counsel (parents/patients) regarding eye safety
- ☐ Stress importance of early, preventative eye care
- ☐ Recommend re-examination, as appropriate

Signed: ____________ Date: ____________
Optometrist/Ophthalmologist

Address: ____________ Telephone: ( ) ____________

Your child's doctor will need to complete the following forms **ONLY** if your child has to take prescription medication at school or has a medical condition that requires special care.

Permission Form for Prescribed or Over-the-Counter Medication

School: ______________________________ Date form received by the School: __________

Student's Name: ______________________ **Grade:** _____ **Homeroom/Classroom:** __________

Student's Age: _______ **Date of Birth:** ____________________

TO BE COMPLETED BY THE PHYSICIAN OR HEALTH CARE PROVIDER FOR PRESCRIPTION MEDICATION

Name of medication: ____________________ Reason for medication: ______________________

Form of medication/treatment: ☐ Tablet/capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Nebulizer ☐ Other ________

Describe schedule and dose to be given at school: ______________________________________

Starting Date: ☐ date form received ☐ Other, as specified: ______________________________

Stopping Date: ☐ for episodic/emergency events only ☐ end of school year ☐ Other date/duration: __________

Restrictions and/or important effects: ☐ Yes. Please describe: __________________________

NOTE: ***In the event the Principal/designee is notified of the possibility of an adverse or extreme reaction to a medication, s/he shall inform the student's teacher(s) of such a possibility before the student begins the medication schedule.***

Special storage requirements: ☐ None ☐ Refrigerate ☐ Other ____________________

Student is capable of/responsible for self-administering this medication: ☐No ☐Yes ☐Supervised ☐Unsupervised

Student has been instructed in self-administering the medication: ☐No ☐Yes

Student must carry this medication on his/her person: ☐No ☐Yes

Please indicate additional information: ☐ On the back side of this form ☐ As an attachment

______________________________________ __________

Physician/Health Care Provider Signature ***Date***

______________________________________ __________

Signature of Parent/Guardian ***Date***

Name of Physician/Health Care Provider: ______________________________________

Address: ____

Phone #: ____________________ **Fax #:** ____________________

To the school: Please report concerns about medications or the student's condition to the above physician/health care provider.

TO BE COMPLETED BY PARENT/GUARDIAN FOR NON-PRESCRIPTION MEDICATIONS

As the parent or legal guardian of the student named below, I authorize my child to take the following over-the-counter medication as noted:

Name of Medication: ______________________ Dosage/Schedule: ____________________

Other Information: ____

Permission Form for Prescribed or Over-the-Counter Medication

FOR ALL MEDICATIONS

I give permission for ________________________________ to receive the above medication(s) at school according
Student's Name
to standard school policy and expressly hold harmless, and waive any liability on behalf of, the school or its employees and agents concerning any injuries or reactions resulting from administration of the above medication unless such is the result of negligence or misconduct on behalf of the school or its employees. For on-going medications, I understand that I have the ultimate responsibility for providing the school with an adequate supply of medication to enable orders from a physician or health care provider to be followed.

Date: ______________ *Signature:* ____________________________________ *Relationship:* _____________

Home Phone: ________________ *Work Phone* ____________________ *Emergency Phone* ________________

TO BE COMPLETED BY SCHOOL PERSONNEL

I/we acknowledge receipt of the foregoing statement and authorization.

Administrator/designee ____ Date ___________________________

For student health services/procedures not involving medication only,
please refer to 09.22 AP.22.

Review/Revised:7/12/11

Request for Student Health Services and Procedures

(NON-MEDICATION NEEDS ONLY)

The District provides health services to students so that their attendance and/or school-related program participation is not interrupted.

If your child requires a specific health service or procedure, please obtain the information below from your child's physician/health care provider and return this completed form to: ____________________________.

Please be advised that District personnel will review the information provided for possible Section 504 or IDEA service considerations.

STUDENT'S NAME ____ **DOB** ____________

STUDENT'S SCHOOL ____

____ ________________

Parent/Guardian or Student 18 or Older Signature *Date*

TO BE COMPLETED BY PHYSICIAN/HEALTH CARE PROVIDER:

Duration of service/procedure: ☐ _______________ school year ☐ until treatment is changed.

Describe the service/procedure in detail and include any specific instructions. (Please use the back of this form if needed, and sign at the end of your additional comments.) ___________

____

____

Times to be administered: ____

____ ________________

Physician/Health Care Provider Signature *Date*

____ ________________

Physician/Health Care Provider Address *Date*

TO ASSURE COMPLIANCE WITH HIPAA REQUIREMENTS, SUBMIT THE ATTACHED "REQUEST FOR PROTECTED HEALTH INFORMATION" FORM TO YOUR HEALTH CARE PROVIDER OR USE THE HIPAA FORM REQUIRED BY THAT PROVIDER.

RELATED PROCEDURES:

03.111 AP.21; 09.2241 (all medication-related procedures)

Review/Revised:7/12/11