KINDERGARTEN HEALTH REQUIREMENTS

Enclosed in this packet are requirements for entrance into kindergarten for the school year. Please read through all enclosed information and see School Nurse with any questions.

Items you need to return from this packet prior to the star of the school year are:

1. **Current Immunization Record** This is a State of Iowa requirement. Complete requirements are enclosed in this packet.
2. **Current Physical From Physician** Please see school nurse with any health concerns such as allergies, asthma, seizures, or chronic health issues.
3. **Dental Screening Form** This can be completed by your dentist or physician at the time of your child's physical.
4. **Vision Screening Form** This can be completed by your doctor at the time of your child's physical IF it is part of their screening. It may also be completed by your eye doctor, community-based organization (Lion's Club), local health department, public or accredited nonpublic school, or childcare center. Enclosed is a consent for a vision screening to be completed by our local Lions Club. Consent MUST be signed and returned for your child to be screened.
5. **KidSight Consent** Sign and return to have your child screened at school in the fall. Form MUST be returned to be screened.

Items can be dropped off, faxed to 712-623-6638, or uploaded to Infinite Campus.

Physical Exam and Assessment
Preschool/ Kindergarten
By Physician, Nurse Practitioner or Physician Assistant

Red Oak Community Schools
Inman Primary School
2011 N. 8th Street
Red Oak, IA 51566
Phone: 712-623-6635 Fax: 712-623-6638

Student ______________________________
Female_____ **Male**_____ **Date of Birth**__________________

Medical and Health History

History	Date	Comments
Allergies: (**All Food Allergies will require a Dietary Modification Form**)		To Medication:______ To Foods:______ To Latex:______ **Epi-pen**: Yes_____ No_____ **Please include allergy Plan**
Asthma: **Please include Asthma Plan from Doctor**		
Medications:		
Illness, serious		
Hospitalization/Surgery		
Immunizations **Attach IRIS Form**	☐ Up to date for school entry ☐ Boosters needed:	
Other:		

Height__________ **Weight**__________ **Blood pressure**__________

Vision: Both 20/_____ **Right 20/**_____ **Left 20/**_____

System	WNL	Comments:
Skin		
Eyes		
Ears/Hearing		
Mouth		
Speech		
Neck		
Heart		
Lungs		
Abdomen		
Genitourinary		
Musculoskeletal		
Neurologic		
Emotional/social		
Lead screening **(required)**		Date: _________ Results:
Dental screening **(required)**		State Dental Form Required
Labs if indicated		

Health conditions requiring intervention/modification at school:

Physical Education Program: Full_____ **Limited**_____ **None**_____
Reason:

Examined by (print) ____________________ **Clinic name:** ____________________ **Phone:** ____________________

Signature ______________________________ **Date:** __________ **Parent/Guardian**____________________
Physician

Iowa Department of Public Health
CERTIFICATE OF DENTAL SCREENING

This certificate is not valid unless all fields are complete.
RETURN COMPLETED FORM TO CHILD'S SCHOOL.

Student Information (please print)

Student Last Name:	Student First Name:	Birth Date (M/D/YYYY):

Screening Information (health care provider must complete this section)

Date of Dental Screening: ______________________

Treatment Needs (check ONE only based on screening results, prior to treatment services provided):

☐ **No Obvious Problems** – the child's hard and soft tissues appear to be visually health and there is no apparent reason for the child to be seen before the next routine dental checkup.

☐ **Requires Dental Care** – tooth decay[1] or a white spot lesion[2] is suspected in one or more teeth, or gum infection[3] is suspected.

☐ **Requires Urgent Dental Care** – obvious tooth decay[1] is present in one or more teeth, there is evidence of injury or severe infection, or the child is experiencing pain.

[1] Tooth Decay: A visible cavity or hole in a tooth with brown or black coloration, or a retained root.
[2] White spot lesion: A demineralized area of a tooth, usually appearing as a chalky, white spot or white line near the gumline. A white spot lesion is considered an early indicator of tooth decay, especially in primary (baby) teeth.
[3] Gum infection: Gum (gingival) tissue is red, bleeding, or swollen.

Screening Provider (check ONE only):

☐ DDS/DMD ☐ RDH ☐ MD/DO ☐ PA ☐ RN/ARNP (High school screen must be provided by DDS/DMD or RDH)

Provider Name: (please print) ______________________ Phone: ______________

Provider Business Address: ______________________

Signature and Credentials of Provider or Recorder*: ______________________ Date: ______________

*Recorder: An authorized provider (DDS/DMD, RDH MD/DO, PA, or RN/ARNP) may transfer information on this form from another health department. The other health document should be attached to this form.

A screening does not replace an exam by a dentist.
Children should have a complete examination by a dentist at least once a year.
RETURN COMPLETED FORM TO CHILD'S SCHOOL.

Iowa Department of Public Health • Oral Health Delivery Systems
515-242-3683 • 866-528-4020 • https://idph.iowa.gov/ohds
A designee of the local board of health or Iowa Department of Public Health may review this certificate for survey purposes.

University of Iowa
Stead Family
Children's Hospital

Iowa KidSight
Consent Form

Date of Screening:____________________

Has this child seen an eye doctor within the last year? ☐ No ☐ Yes

If yes, the screening is not necessary. Continue appointments with your eye doctor.

Free vision screening will be offered to children by a local Lions Club. Screenings are in conjunction with Iowa KidSight, in the Department of Ophthalmology and Visual Sciences at the University of Iowa Stead Family Children's Hospital. Vision screening produces images of a child's eyes to determine the presence of eye disorders including far- and near-sightedness, astigmatism, anisometropia (unequal refractive power), strabismus (misaligned eyes), and media opacities (e.g., cataracts). No physical contact is made with a child and no eye drops are used during the vision screening. This screening is approximately 85-90% effective in detecting problems that can cause reduced vision.

Participation is voluntary. This screening is designed for children 6 months of age through Kindergarten. Children who are younger than 6-months old will not be screened. No child will be screened without a signed and completed consent form. Each individual child needs his/her own consent form. If you have questions, please contact: Iowa KidSight, 2431 Coral Court #5, Coralville, Iowa 52241, or 319-353-7616, or kidsight@uiowa.edu.

Please print or type the information below:

Child's Name ____ (__________)
First Middle Last Initials

Male _____ **Female** _____ **Child's Date of Birth** _____/_____/_____ (MM/DD/YY) **Child's Age** __________

Parent's Name ____

Address ______________________________ **City** ________________ **Zip** __________

Home Phone (_____)____________________ **Work Phone** (_____)____________________

Cell Phone (_____)____________________ **E-mail address** ____________________

I, the undersigned, hereby give permission for my child, ______________________________, to participate in the screening event. I understand the following regarding this program:

1. The information obtained from this screening is preliminary only and does not constitute a diagnosis of vision problems.
2. I will be contacted with the results of the screening through Iowa KidSight at the University of Iowa Stead Family Children's Hospital, or through my child care provider who aided in arranging the screening. I may be contacted regarding follow-up for vision referral by Iowa KidSight staff.
3. This screening result may satisfy the requirement for vision screening upon entry to kindergarten, and may be recorded in the Iowa Immunization Registry.
4. I am responsible for arranging a full eye examination with a doctor of my choosing if my child has been referred as a result of the vision screening. Iowa KidSight recommends a dilated eye examination.
5. The results of your child's eye examination will be shared with Iowa KidSight as a means to help evaluate the screening program's effectiveness.
6. Iowa KidSight will maintain the confidentiality of all records and results.
7. I will not hold the Lions Club and its volunteers, Lions Clubs organizations, University of Iowa Stead Family Children's Hospital, or affiliates, accountable for any errors of commission, omission or other misdiagnosis. There are no foreseeable risks to participating in the Iowa KidSight vision screening.

______________________________________ ____________________
Signature of Parent or Guardian **Date**

Revised 1-2017

STUDENT VISION CARD

Student First/Last Name ______________________ Exam Date ____________

Student Date of Birth _____/_____/______ Student Home Zip Code ____________

TO THE PARENT OR GUARDIAN: To fully assess the health of your child's visual system and prevent future learning problems associated with undetected vision problems, regular professional eye exams are essential. Experts estimate that 80% of learning is obtained through vision. Good vision directly contributes to a child's ability to learn while in school. As a part of your back-to-school preparations, it is recommended that you take your child and this card to your family eye doctor for a complete eye health examination. **This card should be signed by the eye care professional and returned to the school nurse or teacher by your child.**

Visual Acuity	**At Distance**		**At Near**	
☐ Without correction	R20/	L20/	R20/	L20/
☐ With present correction	R20/	L20/	R20/	L20/
☐ With new correction	R20/	L20/	R20/	L20/

External Eye Health
☐ Normal ☐ Other

Internal Eye Health
☐ Normal ☐ Other

Vision Analysis

R	**L**	
☐	☐	Normal eyesight
☐	☐	Nearsighted (myopia)
☐	☐	Farsighted (hyperopia)
☐	☐	Astigmatism
☐	☐	Amblyopia

☐ Eye teaming difficulty
☐ Crossed-eyes (strabismus)
☐ Eye focusing difficulty
☐ Sensitivity to light

☐ Other ______________________________

Vision Correction Recommendations
☐ No correction necessary
☐ No change in present prescription
☐ New prescription needed

To be worn for:
☐ Constant wear
☐ Distance vision only
☐ Near vision only
☐ As needed

TO THE EYE CARE PROFESSIONAL: Please sign and date this card after examination.

Dr. Name: (Please Print) ______________________________

Date______________Signature______________________________

The following organizations recommend the use of the Student Vision Card

To order more cards call 1-800-444-1772 • www.iowaoptometry.org

Iowa Department of Public Health
CERTIFICATE OF VISION SCREENING

RETURN COMPLETED FORM TO CHILD'S SCHOOL.

Student Information (please print)

Student Last Name:	Student First Name:	Birth Date (M/D/YYYY):
Parent/Guardian Telephone Number:	Student Address:	
Zip Code:		

Screening Information (vision screening provider must complete this section *or parents may attach a copy of vision screening results given to them by a provider.*)

Date of Vision Screening: ______________________

Results (visual acuity):

Right Eye__________ Left Eye__________

Overall Result (Please select one):

Pass ○ or Fail ○

Referral to eye health professional (Please select one):

Yes ○ or No ○

Screening Provider: ______________________

Provider Business Name/Source of Screening: (please print) ______________________

Provider Name: (please print) ______________________ Phone: __________

Signature and Credentials of Provider: ______________________ Date: __________

A parent or guardian of a child who is to be enrolled in a public or accredited nonpublic elementary school shall ensure the child is screened for vision impairment at least once before enrollment in Kindergarten **and** again before enrollment in the 3rd grade.

To be valid, a minimum of one child vision screening shall be performed no earlier than one year prior to the date of enrollment in Kindergarten and no later than six months after the date of the child's enrollment in Kindergarten.

To be valid, a minimum of one child vision screening shall be performed no earlier than one year prior to the date of enrollment in 3rd grade and no later than six months after the date of the child's enrollment in 3rd grade.

RETURN COMPLETED FORM TO CHILD'S SCHOOL.

Medication in School

Red Oak Community School District
Red Oak, Iowa

GENERAL MEDICATION GUIDLINES:

1. Prescription medication is ordered by a licensed medical or osteopathic physician or dentist.
2. When a child is to receive medications during school hours, the following conditions shall apply:
   a. No medication shall be kept on the person or with their belongings
   b. No student shall self-administer at school, except under specific conditions and with prior approval by the school nurse.
   c. All medications shall be left in the charge of the nurse or designated school official to be given to a child at the prescribed times.
   d. Medications are furnished by the parent/guardian.
3. Parents may come to school and administer medication to their own children.

REQUIREMENTS FOR ADMINISTRATION IN SCHOOL:

PRESCRIPTION MEDICATION

1. Medication must be in the original container, prepared and labeled by the pharmacist and clearly showing the name of the child, name and dosage of the medication, and administration schedule along with the name of the physician.
2. The label on the pharmacy bottle will serve in lieu of the doctor's written prescription in most cases.
3. Depending upon the type of medication, the school nurse may request that written instructions over the prescribing doctor's signature be on file at the school.
4. Written permission from parent/guardian must be on file at the school.
5. The school nurse may contact the child's doctor if there is any question regarding dosage/administration.

NON-PRESCRIPTION MEDICATION

1. The medication shall be provided by the parent/guardian in the original container labeled by the manufacturer.
2. Written permission form parent/guardian with name of medication, dosage and times of administration shall be on file.
3. The medication will be dispensed according to the instructions and recommendations on the manufacturer's container.
4. The school nurse may determine that such medication should not be administered to the child. In such cases, the nurse shall attempt to contact parent/guardian. The nurse shall notify the parent/guardian in writing that the medication was not given and reasons therefore.