

Jesup Community School
Missy Walztoni, BSN, RN - Pre-School-12th School Nurse
Phone: 319-827-1700 ext. 1105 or Opt. 6
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Please ensure the following requirements are turned in at the time of enrollment.

Forms are attached here or can be found at www.jesup.k12.ia.us

Requirements for Pre-School:

- Current Physical - must be within 6 months of start of school. State of Iowa Requirement
- Current Immunizations - State of Iowa Requirement
- Health Update Form – this informs me of any health conditions, allergies and gives permission to administer medications if needed
- Dental Exam – only if enrolled in Headstart

Requirements for Pre-K:

- Current Physical- must be within 6 months of start of school. State of Iowa Requirement
- Current Immunizations – State of Iowa Requirement
- Health Update Form
- Dental Exam – only if enrolled in Headstart

Requirements for Kindergarten:

- Current Physical or Health Update Form - Jesup CSD requirement
- Lead Screening- State of Iowa Requirement. Typically done with physical - All children enrolling in Kindergarten are required to have at least one lead test to be in compliance with IAC 641 Chapter 67.
- Dental Exam- State of Iowa Dental Form signed by dentist or dental hygienist. For kindergarten, a screening completed no earlier than age 3, but no later than four months after enrollment is acceptable. All children enrolling in Kindergarten are required to have a dental in compliance with IDPH 641 Chapter 51.
- Vision Exam- State of Iowa Requirement. Each Kindergartner shall have a valid vision screening performed no earlier than 1 year prior to enrollment and no more than 6 months after the date of the child's enrollment in compliance with IAC 641 Chapter 52.
 - Our local Lion's club will provide a FREE screening at the beginning of the school year if consent signed. Consent will be sent home from school.

Thank you!

Missy Walztoni, BSN, RN

REQUIRED of all students every year.
Parent/Guardian completes form.

Jesup Community School Health Information

Name of student: _____ Birthdate: _____ Grade: _____

- | | | | |
|--|--|--|------------------------|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Asthma or bronchospasms | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | ADD/ADHD/Behavior Issues | <input type="checkbox"/> Yes <input type="checkbox"/> No | Seizures |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Migraine headaches |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Blood pressure problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Depression/Anxiety |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney/urinary problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stomach/bowel problems |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Wears glasses/contacts/vision concerns | <input type="checkbox"/> Yes <input type="checkbox"/> No | Eczema |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Other please list below | | |

Comments: _____

List ALL medications taken, whether given at school or at home.

Medication	Dosage	How often given	Diagnosis	Given at School?

Please list all allergies, including foods, environmental allergies, latex or medications

Allergic to:	Reaction	Treatment

Explain any serious illness, injury or surgery that you child has had: _____

Does your child have any other health or emotional concerns: If yes, please explain: _____

Has your child had a: Dental visit in the last year? Yes No Dentist's Name _____

Physical exam in the last year? Yes No Name of child's physician(s) _____

I give permission for my child to receive an Epinephrine Injection if he/she is experiencing symptoms of a life-threatening anaphylactic reaction if deemed necessary by a trained individual. Yes No

I give permission to the school health staff to share information relevant to my child's health condition with the appropriate school personnel on an as-needed basis to meet my child's health and safety needs. Yes No

I give permission to the Jesup Community schools to give my child a weight appropriate dose of acetaminophen and ibuprofen if deemed necessary by school staff. Yes No

I give permission to the Jesup Community Schools to give my child antacids, cough drops, and over-the-counter topical ointments (antibiotic ointment, hydrocortisone, Caladryl, lip ointment, etc.) if deemed necessary by school staff. Yes No If No, please specify _____

I give permission to the Jesup Community Schools to apply a 'mask' to kids if they are sick with a fever and/or respiratory symptoms Yes No

If a student requires over-the-counter pain medications more than 15 times during the school year, further permission from a healthcare provider will be required before additional doses will be given. No more than 15 doses will be given per year. Any over-the-counter medication that is taken long term at school must have a MD, DO, PA, or ARNP written approval.

Signature of parent/guardian

Date

Emergency phone: _____ Hospital Preference _____

If this number changes during the school year, notify the school office immediately.

Jesup Community Schools PS, PK and Kindergarten Physical form

Student Name (F,M,L) _____ M __ F __ Birth Date _____

Parent/Guardian _____

Family Doctor _____

Medications taken regularly _____

Conditions that would alter school performance _____

PHYSICAL EXAMINATION

Date of Visit _____ Height _____ Weight _____ Blood Pressure _____

General Appearance	
Posture	
Nutrition	
Skin	
Feet	
Nose/Throat	
Eyes/ Ears	
Vision	
Tonsils/ Glands	
Head/ Lungs	
Abdomen	
Genitals	
Other	

Urinalysis	
Blood Count	
Immunizations Given:	

Comments: _____

PHYSICIANS SIGNATURE _____ Date: _____



REQUIRED for PS, PK and new students

Iowa Department of Public Health Certificate of Immunization

Name Last: Provided from your Doctor's office First: _____ Middle: _____ Date of Birth: _____

Parent/Guardian: _____ Address: _____ Phone: _____

I certify that the above named applicant has a record of age-appropriate immunizations that meet the requirement for licensed child care or school enrollment.

Signature: _____ Date: _____

Physician, Physician Assistant, Nurse, or Certified Medical Assistant

A representative of the local Board of Health or Iowa Department of Public Health may review this certificate for survey purposes.

Diphtheria, Tetanus, Pertussis DTaP/DTP/DT/ Td/Tdap	Vaccine	Date Given	Doctor / Clinic / Source

Polio IPV/OPV	Vaccine	Date Given	Doctor / Clinic / Source

Measles, Mumps, Rubella MMR	Vaccine	Date Given	Doctor / Clinic / Source

Haemophilus influenzae type b Hib	Vaccine	Date Given	Doctor / Clinic / Source

Hepatitis B	Vaccine	Date Given	Doctor / Clinic / Source

Varicella Chicken Pox	Vaccine	Date Given	Doctor / Clinic / Source

If applicant has a history of natural disease write "Immune to Varicella"

Pneumococcal PCV/PPSV	Vaccine	Date Given	Doctor / Clinic / Source

Meningococcal MCV/MPSV/ Mening B	Vaccine	Date Given	Doctor / Clinic / Source

Hepatitis A	Vaccine	Date Given	Doctor / Clinic / Source

Rotavirus	Vaccine	Date Given	Doctor / Clinic / Source

Human Papilloma Virus HPV	Vaccine	Date Given	Doctor / Clinic / Source

Other	Vaccine	Date Given	Doctor / Clinic / Source



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):
Parent or Guardian Name:		Telephone (home or mobile):
Street Address:	City:	County:
Name of Elementary or High School:	Grade Level:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female

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 healthy and there is no apparent reason for the child to be seen before the next routine dental checkup.
- Requires Dental Care** – tooth decay¹ or a white spot lesion² is suspected in one or more teeth, or gum infection³ is suspected.
- Requires Urgent Dental Care** – obvious tooth decay¹ 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 onto this form from another health document. 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 Center

515-242-6383 • 866-528-4020 • www.idph.state.ia.us/ohds/OralHealth.aspx

A designee of the local board of health or Iowa Department of Public Health may review this certificate for survey purposes.