Jesup Community School

From the desk of the school nurse

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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
- Complete Health Update Form (informs me of any health conditions, allergies and give permission to administer medications if needed)

Requirements for Pre-K:

- Current Physical- must be within 6 months of start of school. State of Iowa Requirement. Need to complete
- Health Update Form, provided by school, or can get online.
- Current Immunizations- If child attended Pre-School at Jesup, we have record on file. Please advise if your child received any new immunizations within the past year.

Requirements for Kindergarten:

- Current Physical or Health Update Form. Jesup CSD requirement.
- Lead Screening- State of Iowa Requirement. 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. All children enrolling in Kindergarten are required to have a dental in compliance with IDPH 641 Chapter 51. Dental form is online, or can request copy from nurse.
- 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**.*

Please call or e-mail me with any questions.
Thanks!
Christy VanBrocklin, RN

02/2020

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

Jesup Community School Health Information

Name of student: _____ Birthdate:_____ Grade: _____

_____ Yes _____ No Asthma or bronchospasms
_____ Yes _____ No ADD/ADHD/Behavior Issues
_____ Yes _____ No Heart Problems
_____ Yes _____ No Blood pressure problems
_____ Yes _____ No Kidney/urinary problems
_____ Yes _____ No Wears glasses/contacts/vision concerns
_____ Yes _____ No Other please list below

_____ Yes _____ No Diabetes
_____ Yes _____ No Seizures
_____ Yes _____ No Migraine headaches
_____ Yes _____ No Depression/Anxiety
_____ Yes _____ No Stomach/bowel problems
_____ Yes _____ No Eczema

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.

Example form for Healthcare Provider

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

Provided from your Doctor's office

Iowa Department of Public Health
Certificate of Immunization

Name Last: _____ 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.

	Vaccine	Date Given	Doctor / Clinic / Source
Diphtheria, Tetanus, Pertussis DTaP/DTP/DT/ Td/Tdap			
Polio IPV/OPV			
Measles, Mumps, Rubella MMR			
***Haemophilus influenzae* type b** Hib			
Hepatitis B			

	Vaccine	Date Given	Doctor / Clinic / Source
Varicella Chicken Pox *If applicant has a history of natural disease write "Immune to Varicella"*			
Pneumococcal PCV/PPSV			
Meningococcal MCV/MPSV/ Mening B			
Hepatitis A			
Rotavirus			
Human Papilloma Virus HPV			
Other			

January 2013

REQUIRED for Kindergarten

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: ☐ Male ☐ 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 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 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.