CROWN POINT COMMUNITY SCHOOL CORPORATION

KINDERGARTEN MEDICAL-PHYSICAL RECORD

Dear Parents:

To help your child have the best possible start in school he/she should be in the best physical condition. You are asked to take your child to your family physician or pediatrician for a medical examination and to your dentist for a check-up. If any immunizations have not been completed or if boosters are needed they should be given as soon as possible; your doctor would prefer to do this before the summer months.

The School Immunization Rule (410 IAC 1-1-1) states that, "the adequately immunizing doses and the child's age for administering each vaccine shall be those recommended in the current Report of the Committee on Infectious Diseases of the American Academy of Pediatrics (AAP) or those currently recommended by the United States Public Health Service, Advisory Committee on Immunization Practices (ACIP)."
Upon enrollment of a student in any school corporation in the State of Indiana the parents must furnish proof of the following:

1. The minimum Immunization Requirements for all children newly enrolled in kindergarten.

   - 5 doses of diphtheria-tetanus-acellular pertussis (DtaP), diphtheria-tetanus-pertussis (DTP), or pediatric diphtheria-tetanus vaccine (DT) or 4 doses are acceptable if the fourth dose was administered on or after the fourth birthday and at least 6 months after the 3rd dose
   - 4 doses of inactivated polio vaccine (IPV), with the 4th dose being administered on or after the 4th birthday and at least 6 months after the 3rd dose or 3 doses of IPV are acceptable if the third dose was administered on or after the fourth birthday and at least 6 months after the 2nd dose
   - 2 doses of measles (rubeola) vaccine, first dose on or after the first birthday
   - 1 dose of rubella (German measles) vaccine, on or after the first birthday
   - 2 doses of mumps vaccine, on or after the first birthday
   - 2 doses of varicella (chicken pox) vaccine with first dose on or after 1st birthday and second dose at least 3 months later or documented date of disease from your physician
   - 3 doses of hepatitis B vaccine appropriately spaced with the 3rd dose on or after age 24 weeks and at least 8 weeks after the 2nd dose
   - 2 doses of hepatitis A vaccine, first dose administered on or after first birthday with 2nd dose given at least 6 months later.

   Indiana has only two exceptions to this law, a medical exemption or a religious objection. (Parent must provide the school verification of exception each school year.)

   - **Religious** – Parents must provide the school with a signed exemption form stating that the objection to immunizations is based on religious reasons.
   - **Medical** – A signed physician's statement that a <u>particular</u> immunization is **detrimental** to the child's health must be provided to the school.

   <u>Refusal or neglect to comply with this law will result in mandatory exclusion of the child from school until compliance has been met. (Public Law 130, Acts 1976)</u>

   ALL FORMS MUST BE RETURNED TO THE SCHOOL BY THE PARENT ON OR BEFORE THE FIRST DAY OF SCHOOL...NO CHILD WILL BE ADMITTED TO SCHOOL UNTIL ALL FORMS ARE ON FILE.

CROWN POINT COMMUNITY SCHOOL CORPORATION

KINDERGARTEN MEDICAL-PHYSICAL RECORD

Student's Name_____ Sex: M F Date of Birth_____

Address_____ Phone_____

Father's name_____ Mother's name_____

Doctor_____Phone_____Dentist_____Phone_____

HISTORY: (To be completed by parents before going to the doctor) Please write yes/no on the line provided.
Has your child had the following?
Diabetes _____ Asthma_____

Epilepsy (seizures)_____ Allergies_____, please specify:_____

Chicken pox: Had Disease_____ Date: _____
(month and year)
Does your child take medication? _____ Explain_____

Does your child have hearing loss?_____ Does your child wear glasses?_____

Date of last exam by eye doctor_____

Accidents (describe & list date) _____

Operations (describe & list date) _____

Other information: _____

I give the school nurse permission to share this or any other health condition information on my child's health record with school personnel who have a need to know in order to meet the health and safety needs of my child. Please contact the school nurse with all health concerns.

Date _____ Parent/Guardian signature: _____

PHYSICAL EXAMINATION RECORD: (To be completed by doctor)

Height_____ **Weight**_____ **BP**_____ **Pulse**_____

Vision: RT_____ LT_____ **Hearing**: RT_____ LT_____

Heart_____ **Lungs**_____ **Abdomen** _____

Extremities_____ **Scoliosis**: positive _____ negative_____

Should physical activities be restricted? _____
Comments or recommendations: _____

_____
Date Signature of Physician Degree Printed Name

Address_____ Phone_____

****Immunization record on back or attach current immunization record ****

CROWN POINT COMMUNITY SCHOOL CORPORATION

KINDERGARTEN MEDICAL-PHYSICAL RECORD

Student's Name_____
First Last

IMMUNIZATIONS : (To be verified by doctor or health agency. **The month, day, and year are required**.)

Dtap / Diphtheria/Tetanus/Pertussis Boosters

#1	#2	#3	#4	#5	

Polio (IPV) Boosters

#1	#2	#3	#4		

HIB (not mandatory)

#1	#2	#3	#4

Prevnar (not mandatory)

#1	#2	#3	#4

Hepatitis B Vaccine: 1st dose_____ 2nd dose_____ 3rd dose_____

Hepatitis A Vaccine: 1st dose_____ 2nd dose_____

Measles/Mumps/Rubella (M/M/R): (on or after 1st birthday)
Measles #1_____ #2_____ (2 doses needed)
Mumps #1_____ #2_____ (2 doses needed)
Rubella #1_____ #2_____ (1 dose needed)

Varicella vaccine: Date_____ (on or after 1st birthday)
Varicella Booster: Date_____ (3 months after first vaccine)

Had Disease: Date_____ (month and year)

Flu vaccine: Date:_____ Date:_____ Date:_____ (not mandatory)

_____ (Doctor's/health care agency's initials)

2/7/2022

Crown Point Community School Corporation
Kindergarten Medical-Physical Record

Kindergarten Dental Examination Record

I have examined the teeth of:

_____, and

Please check:

_____ 1. All necessary dental work has been completed.

_____ 2. Treatment is in progress.

_____ 3. No dental work is necessary.

_____ 4. Other: _____

_____ _____ D.D.S.

Date Signature of Dentist

_____

Printed Name of Dentist