KDE/DDS

KDESHS002

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: _____

KDE/DSS **Kentucky Eye Examination Form for School Entry** **KDESHS0**

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: ( ) _____

Kentucky Dental Screening/Examination Form for School Entry January 2011

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 Enrollment ____/____/____

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 ☐ LHD Registered Nurse with KIDS Smiles training

☐ ARNP ☐ 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 (rev, 1/25/11)

Permission Form for Prescribed Medication

TO BE COMPLETED BY SCHOOL PERSONNEL

School:_____ Date form received:_____

I/we acknowledge receipt of this Physician's Statement and Parent Authorization._____

Student Name:_____ Student age:_____ Date of Birth:_____

Grade:_____ Homeroom/Classroom:_____

TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED PROVIDER

Name of medication:_____

Reason for medication:_____

Form of medication/treatment:

☐ Tablet/capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Nebulizer ☐ Other_____

Instructions (Schedule and dose to be given at school):_____

_____

Start: ☐ Date form received ☐ Other, as specified:_____

Stop: ☐ End of school year ☐ Other date/duration:_____

For episodic/emergency events only

Restrictions and/or important side effects: ☐ No restriction

☐ Yes. Please describe:_____

_____

Special storage requirements: ☐ None ☐ Refrigerate

Other:_____

Physician's Signature_____ Physician's Name:_____

Date_____ Phone_____ Address:_____

For Self-Administration ONLY For Self-Administration ONLY For Self-Administration ONLY For Self-Administration ONLY

This student has been trained on self-administration of this medication: to be completed for asthmatic, diabetic or severe allergy ONLY

☐ No ☐ Supervision required ☐ Supervision not required

This student may carry this medication: ☐ No ☐ Yes

Please indicate if you have provided additional information

☐ On the back: side of this form ☐ As an attachment

Signature:_____ Date_____

Physician or Authorized Provider

TO BE COMPLETED BY PARENT / GUARDIAN

I give permission for (name of child)_____ is to receive the above stated medication at school according to standard school policy. I release the Bracken County School Board and its employees from any claims or liability connected with its reliance on this permission. (Parent/guardians to bring the medication in its original container.)

Date:_____ Signature:_____ Relationship:_____

Home phone:_____ Work phone:_____ Emergency phone:_____

School Year:_____

Permission Form for Over the Counter Medication

**ALL medications must be turned into the office immediately upon entering school.

Child's Name_____ ____/____/_____ [ ] Female [ ] Male
(Please Print) Last First Middle Date of Birth

TO BE COMPLETED BY THE PARENT/GUARDIAN: I give permission for my child to receive the below medication at school according to school policy (09.2241) throughout this school year. I release Bracken County School Board and its employees from any claims or liability connected with its reliance on this permission.

X_____ _____

Parent/Guardian's Signature Date

PLEASE CHECK ALL THAT APPLY	OVER THE COUNTER MEDICINE	FOR WHAT SYMPTOMS	DOSAGE
	ACETAMINOPHEN / TYLENOL		
	ALOE VERA		
	ANTIBIOTIC OINTMENT		
	BENADRYL (DIPHENHYDRAMINE)		
	CALAMINE LOTION		
	CARMEX		
	COUGH DROPS / SYRUP		
	EYE DROPS		
	HYDROCORTISONE CREAM		
	HYDROGEN PEROXIDE / RUBBING ALCOHOL		
	IBUPROFEN / MOTRIN		
	MUSCLE RUB		
	ORAGEL		
	PEPTO BISMOL/IMMODIUM/ ANTACIDS		
	SUDAFED		
	OTHER:		

TO BE COMPLETED BY SCHOOL PERSONNEL

School:_____Date form received:_____

I/we acknowledge receipt of the Parent Authorization for OTC Medication:_____

COMMONWEALTH OF KENTUCKY
CERTIFICATE OF IMMUNIZATION STATUS

Certificate Issuing Office Name and Address

Name of Child: _____ **Birthdate:** _____
(Last) (First) (Middle) (Suffix) (MM/DD/YYYY)

Name of Parent: _____
(Last) (First) (Middle) (Suffix)

Address: _____
(Street) (City) (State) (Zip Code)

VACCINE	DOSE 1 MM/DD/YYYY	DOSE 2 MM/DD/YYYY	DOSE 3 MM/DD/YYYY	DOSE 4 MM/DD/YYYY	DOSE 5 MM/DD/YYYY
Hepatitis B	/ /	/ /	/ /	/ /	
Alt. Adult Hepatitis B[1]	/ /	/ /			
DTaP/DTP/DT[2]	/ /	/ /	/ /	/ /	/ /
Hib[3]	/ /	/ /	/ /	/ /	
Pneumococcal (PCV13)	/ /	/ /	/ /	/ /	
Polio	/ /	/ /	/ /	/ /	/ /
MMR	/ /	/ /			
Varicella	/ /	/ /	Had Chickenpox or Zoster Disease Yes No		/ /
Hepatitis A	/ /	/ /			
Meningococcal	/ /	/ /			
Td	/ /	/ /			
Tdap	/ /	/ /			
Rotavirus	/ /	/ /	/ /		
HPV	/ /	/ /	/ /		
Men B	/ /	/ /	/ /		
Pneumococcal (PPSV23)	/ /	/ /			

[1]Alternative two dose series of approved adult hepatitis B vaccine for adolescents 11 through 15 years of age. [2]DTaP, DTP, or DT. [3]Hib not required at 5 years of age or more.

☐ 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.

☐ This child is not up-to-date at this time. This certificate is valid until ___/___/____, (14 days after the next shot is due) after which this certificate is no longer valid, and a new certificate must be obtained.

Reason child is not up-to-date:

☐ **Provisional Status** - Child is behind on required immunizations.

☐ **Medical Exemption** - The following immunizations are not medically indicated: _____

_____

If Medical Exemption, can these vaccines be administered at a later date? **No:** _____ **Yes:** _____ **Date:** ___/___/___

☐ **Religious Objection**

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

_____ _____
(Signature of physician, APRN, PA, pharmacist, LHD administrator, RN or LPN designee) (Date)

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.

Kentucky UNBRIDLED SPIRIT

Commonwealth of Kentucky

Parent or Guardian's Declination on Religious Grounds to Required Immunizations

The Centers for Disease Control and Prevention (CDC) and Kentucky Department for Public Health (KDPH) recognize immunization as one of the most effective tools in preventing disease and reducing the risks associated with exposure to certain diseases. KRS 214.036 requires parents who object to immunization of their child to provide a written sworn statement objecting to immunization of the child on religious grounds.

Place an "X" in a box or boxes to the left of each disease, listed below, for which you object to your child receiving the immunization. Initial and date the box on the right.

☐	**Hepatitis B:** According to the CDC and KDPH, serious symptoms and effects of this disease include: jaundice (yellow skin or eyes), life-long liver problems, such as scarring and liver cancer, or death.	Initials_____ Date _____
☐	**Diphtheria (DTaP, DT, Tdap, Td):** According to the CDC and KDPH, serious symptoms and effects of this disease include: heart failure, paralysis (can't move parts of the body), breathing problems, coma, or death.	Initials_____ Date _____
☐	**Tetanus (DTaP, DT, Tdap, Td):** According to the CDC and KDPH, serious symptoms and effects of this disease include: "locking" of the jaw, difficulty in swallowing and breathing, seizures (jerking and staring), painful tightening of muscles in the head and neck, or death.	Initials_____ Date _____
☐	**Pertussis (Whooping Cough) (DTaP, Tdap):** According to the CDC and KDPH, serious symptoms and effects of this disease include: severe coughing fits that can cause vomiting and exhaustion, pneumonia, seizures (jerking and staring), brain damage, or death.	Initials_____ Date _____
☐	***Haemophilus influenzae* type b (Hib):** According to the CDC and KDPH, serious symptoms and effects of this disease include: meningitis (infection of the brain and spinal cord covering), pneumonia, severe swelling in the throat that makes it hard to breathe, infections of the blood, joints, bones, and covering of the heart, or death.	Initials_____ Date _____
☐	**Pneumococcal:** According to the CDC and KDPH, serious symptoms and effects of this disease include: chest pain with rapid breathing or difficulty breathing, a high fever, shaking, chills, excessive sweating, fatigue, confusion, and a cough with phlegm that persists or worsens, pneumonia, brain damage, or death.	Initials_____ Date _____
☐	**Polio:** According to the CDC and KDPH, serious symptoms and effects of this disease include: paralysis (can't move parts of the body), meningitis (infection of the brain and spinal cord covering), permanent disability, or death.	Initials_____ Date _____
☐	**Measles, Mumps, Rubella (MMR):** According to the CDC and KDPH, serious symptoms and effects of measles include: pneumonia, seizures (jerking and staring), brain damage, or death. Serious symptoms and effects of mumps include: meningitis (infection of the brain and spinal cord covering), painful swelling of the testicles or ovaries, sterility, deafness, or death. Serious symptoms and effects of rubella include: rash, arthritis, and muscle or joint pain. If a woman gets rubella while she is pregnant, she could have a miscarriage or her baby could be born with serious birth defects such as deafness, heart problems, or learning disability.	Initials_____ Date _____
☐	**Varicella (Chickenpox):** According to the CDC and KDPH, serious symptoms and effects of this disease include: severe skin infections, pneumonia, brain damage, or death.	Initials_____ Date _____
☐	**Hepatitis A:** According to the CDC and KDPH, serious symptoms and effects of this disease include: jaundice (yellow skin or eyes), "flu-like" illness, hospitalization, or death.	Initials_____ Date _____
☐	**Meningococcal:** According to the CDC and KDPH, serious symptoms and effects of this disease include: severe headache, stiff neck, confusion, seizures (jerking and staring), high fever, nausea and vomiting, sensitivity of eyes to light, hearing loss, pneumonia, brain damage, or death.	Initials_____ Date _____

Due to my religious beliefs, I object to my child receiving the required immunizations selected above. I am aware that if I change my mind, I can rescind this objection and obtain immunizations for my child. Initials _____

- *Additional information about vaccine preventable diseases, immunizations and reduced or no cost immunization ~~n~~ services is available from the local health department in each county.*
- *In the event that the county health department or state health department declares an outbreak of a vaccine-preventable disease for which proof of immunity for a child cannot be provided, he or she may not be allowed to attend childcare or school for up to three (3) weeks, or until the risk period ends.*

Child's Name _____
Last First Middle

Child's Date of Birth _____
MM/DD/YYYY

Parent Signature _____

Date _____
MM/DD/YYYY

To be completed by Notary Public

STATE OF)

COUNTY OF)

Subscribed, sworn to or affirmed under oath and acknowledged before me, a Notary Public in and for the state and county aforesaid by _____, on this the _____ day of _____, 20_____.

_____
Notary Public, State at Large

My Commission Expires:_____