

**ZION LUTHERAN SCHOOL**  
Seymour, IN 47274

Dear Parent and/or Guardians,

We hope that you find your child's Kindergarten year an exciting one.

If your child has any special needs that need to be addressed at school, please let us know. I will be happy to meet with you if you have any questions or concerns related to your child's health.

If you would like to meet with the school nurse, please fill out the form below and return it to the school office.

Please have your medical providers complete the attached examination forms concerning your Kindergarten child. **These completed forms, along with a copy of your child's birth certificate, must be turned into the ZLS school office by the first day of school.**

Thank you,  
Zion Lutheran School  
Principal

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I would like to meet with the Principal, concerning issues with my child's health.

YES \_\_\_\_\_ NO \_\_\_\_\_

Child's Name \_\_\_\_\_

Parent's Name \_\_\_\_\_

Phone Number \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# ZION LUTHERAN SCHOOL

## Health Examination Form

Child's Name \_\_\_\_\_

Exam Date: \_\_\_\_\_

Date of Birth \_\_\_\_\_

School child will be attending: Zion Lutheran School

Allergies: \_\_\_\_\_

Will an Epi Pen be needed at school: \_\_\_\_\_

**PHYSICAL EXAMINATION** (code: No Defect 0 Defect – Note)

### Immunizations

DTP/DT/TD 1. \_\_\_\_\_

DtaP 2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

6. \_\_\_\_\_

Polio 1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

MMR 1. \_\_\_\_\_

2. \_\_\_\_\_

HBV 1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

Varicella 1. \_\_\_\_\_

2. \_\_\_\_\_

Chickenpox Disease \_\_\_\_\_ YES

\_\_\_\_\_ NO

Date: \_\_\_\_\_

Hep A 1. \_\_\_\_\_

2. \_\_\_\_\_

Height \_\_\_\_\_

Weight \_\_\_\_\_

Head \_\_\_\_\_

Eyes \_\_\_\_\_

Ears \_\_\_\_\_

Nose \_\_\_\_\_

Throat \_\_\_\_\_

Heart \_\_\_\_\_

B/P \_\_\_\_\_

Lungs \_\_\_\_\_

Abdomen \_\_\_\_\_

Posture \_\_\_\_\_

Operations \_\_\_\_\_

\_\_\_\_\_

Serious Illness/Injuries

\_\_\_\_\_

\_\_\_\_\_

Is there any condition which should be considered in planning this child's school program?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
MD signature

**ZION LUTHERAN SCHOOL**  
Dental Examination Form

Child's Name \_\_\_\_\_

Date: \_\_\_\_\_

Date of Birth \_\_\_\_\_

School child will be attending: \_\_\_\_\_ Zion Lutheran School \_\_\_\_\_

**DENTAL EXAMINATION**  
(code: No Defect      0 Defect – Note)

**TEETH:**

Cavities \_\_\_\_\_

Malocclusions \_\_\_\_\_

**PRESENT STATUS:**

Restorations \_\_\_\_\_

**APPOINTMENTS SCHEDULED:** \_\_\_\_\_

**RECOMMENDATIONS:** \_\_\_\_\_

Date of Exam: \_\_\_\_\_

\_\_\_\_\_  
DDS Signature

**ZION LUTHERAN SCHOOL**  
Eye Examination Form

Child's Name \_\_\_\_\_

Date: \_\_\_\_\_

Date of Birth \_\_\_\_\_

School child will be attending:       Zion Lutheran School      

**STUDENT VISION REPORT**

1. Visual Acuity		Pass		Fail
		<u>Distance</u>		<u>Near</u>
Undecided	R. eye 20/	L. eye 20/	R. eye 20/	L. eye 20/
Corrected	R. eye 20/	L. eye 20/	R. eye 20/	L. eye 20/

Remarks: \_\_\_\_\_

2. Refractive Error Pass Fail

Remarks: \_\_\_\_\_

3. Ocular Health Pass Fail

Remarks: \_\_\_\_\_

4. Eye Muscle Balance Pass Fail

Remarks: \_\_\_\_\_

5. Binocular Depth Perception Pass Fail

Remarks: \_\_\_\_\_

6. Accommodation (Focusing Ability) Pass Fail

Remarks: \_\_\_\_\_

7. Color Perception Pass Fail

Remarks: \_\_\_\_\_

8. Other Remarks: \_\_\_\_\_

\*Analysis of Vision and Eye Health \_\_\_\_\_

Recommendations \_\_\_\_\_

No Treatment Indicated \_\_\_\_\_

Glasses/Contacts \_\_\_\_\_

Prescribed \_\_\_\_\_

Present Prescription Satisfactory \_\_\_\_\_

Vision Therapy \_\_\_\_\_

Other \_\_\_\_\_

OVER

Purpose of Glasses/Contact Lenses (if prescribed) \_\_\_\_\_  
Should be worn: (a) Constant wear      (b) Desk Work Only      (c) Far Vision Only

Recommendations for Classroom Teacher \_\_\_\_\_

Re-examination advised in \_\_\_\_\_

I, being licensed to practice optometry and/or ophthalmology, certify that this child's vision and eye health have been examined by me and:

Are sufficient to enter Kindergarten \_\_\_\_\_

Or

Appropriate treatment has been recommended for deficiencies in this child's vision or eye health \_\_\_\_\_

Date \_\_\_\_\_

Signed \_\_\_\_\_