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,
Chrissy Heiss
Principal

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

YES________ NO_________

Child's Name ______________________________________

Parent's Name ______________________________________

Phone Number ________________________

Comments:____

____

____

Zion Lutheran School
1501 Gaiser Drive
Seymour, Indiana 47274

I, ______________________________, give Zion Lutheran School, permission to release the following immunization and demographic information concerning my child, ____________________________, to the Indiana State Department of Health's secure website CHIRP- Children and Hoosiers Immunization Registry Program.
The CHIRP database is a valuable tool to securely store your child's immunization information for life and only authorized personnel can access this information. Having this information stored in one place makes it easier to apply to colleges and universities. It also helps prevent duplication of vaccine administration. Your child's immunization history may already be entered on the CHIRP database if he/she received immunization at a local health department or through a participating physician's office. To enter your child's immunization history on the CHIRP database we need the following information for your child.

Name: ____ Birthdate _______________

Address: ____

Phone number: _______________________________________

Parent's Name: _______________________________________

I understand that the information in the registry may be used to verify that my child has received proper and age appropriate immunizations and to inform me of my child's immunization status or that an immunization is due according to the ACIP recommended immunization schedule.

I understand that my child's information may be available to authorized personnel only of an immunization data registry of another state, a healthcare provider, a local health department, an elementary or secondary school, a child care center, the Office of Medicaid policy and planning, a licensed child placing agency, and a college or university. I also understand that other entities may be added to this list through amendment to I.C. 16-38-5-3.

I hereby consent to the release of such information.

____ ________________________
Signature Date

____
Printed name of Parent or Guardian

____ ________________________
Address Phone number

____ ________________________
Child's Name Grade Level

____
School

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

		Distance		Near	
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 ___________________________________