Allen County Non-Public School Association

Grades 1-8 Health Forms
2022-2023

Contents:

All forms should be returned to the school office no later than the first day of school or AS SOON AS POSSIBLE!

General Health Information

Physicals/Health Questionnaire: All students new to our school are required to have a recent physical signed by their physician along with the "Health Questionnaire" form filled out by the parents/guardians. **These forms must be submitted to the school office no later than the first day of school.**

CHIRP: As required by IC 20-34-4-6, we report immunizations to the State Department of Health each year on all students in grades K, 1 and 6. This report is currently done online through CHIRP (Children and Hoosier Immunization Registry Program) and we will need a consent signed for each child in order to report this information to the state. **This form needs to be submitted to the school office no later than the first day of school.**

Immunizations: IC 20-34-4-2 requires that **ALL** students have the required immunizations **PRIOR** to, **and on file with, the school before the first day of school**. These immunizations need to be given according to the ACIP (Advisory Committee on Immunization Practices) and the Indiana State Department of Health, this includes proper intervals between each required dose.
The only exception to this rule is a signed "Medical Exemption" form filled out by your child's physician (IC 20-34-3-3), or a "Religious Objection" form signed by the parents/legal guardians (IC 20-34-3-2) stating that it is against your family's religious beliefs. Please contact the nurse if you need either of these forms.
Unfortunately, if this is not completed by the first day of school, you will receive a letter excluding your child from school until the immunizations have been obtained and proper paperwork has been filed.

When your child is ill: Children with fever, diarrhea, vomiting or other symptoms of illness should stay at home, and, if indicated, be evaluated by the doctor for diagnosis and appropriate treatment. Any fever of **99.9** degrees or above means that your child **must stay home for at least 24 hours** (free of fever **and** without the use of acetaminophen or ibuprofen). This means that if your child was sent home from school the day before with a fever, they need to wait **at least** 24 hours before they will be admitted back to school.

Medications: We will only administer FDA approved over–the–counter (OTC) and prescription medications prescribed to your child (this does not include any herbal medications). These medications need to be brought to school by an adult in their original package and accompanied by the medication consent form found on our website or in the school office. Medication brought in to school will only be available during school hours. Our school policies are in accordance with IC 20-34-3-18. All medication will be kept in a locked cabinet with the nurse, or trained staff member dispensing according to the package instructions. Students are not to have medication with them at any time. The only exception to this is if your child needs emergency medication (ex. insulin, an inhaler or an epinephrine injection) and the proper paperwork is filled out and on file with the school. (Forms may be found in the school office.) If needed, this form requires a signature from your child's physician and is only for their EMERGENCY medication. These policies are in place to keep your child and others in the building as safe as they can be during the school day. A reminder that all cough drops are considered OTC medication and need to be kept in the school office for your child's use. Please read our full medication policy on the reverse side of the "Medication Consent" form.

Please understand that NO medication can be sent home with your child.

(reviewed ACNPSA 1/20)

Health Screening Information

During the school year, the following health screenings will take place as part of the health services to your child, and fulfillment of the health screening laws of the State of Indiana. Some students will receive referral letters from the school nurse as the result of these screenings.

HEARING SCREENING

Hearing screenings will be conducted according to IC 20-34-3-14, on all students in grades **1-4-7, and 10** as mandated by the state. We will also check all students new to the school, and any others by special request. The school nurse, or trained volunteers, will conduct this screening. Re-checks will be done at least 2 weeks later on students who have questionable results and referral letters will be sent to those who do not meet the required thresholds on these rechecks. The school nurse will also notify the teachers of those students that referral letters are sent to.

PLEASE COMPLETE AND RETURN ALL REFERRAL FORMS TO THE ATTENTION OF THE SCHOOL NURSE.

VISION SCREENING

Both far and near vision screening will be conducted according to IC 20-31-3-12 for all students in grades **3-5-8**. We will also check all students by special request. The school nurse, or trained volunteers, will conduct this screening. This Indiana Law also requires that **either K or grade 1** be examined by an eye professional, so we have decided to send all of our kindergarten students for the FREE exam that local eye Dr's have offered to us. Re-checks will be done on students who have questionable results and referral letters will be sent to those who do not meet the minimum requirements on these rechecks. The school nurse will also notify the teachers of those students that referral letters are sent to.

PLEASE COMPLETE AND RETURN ALL REFERRAL FORMS TO THE ATTENTION OF THE SCHOOL NURSE.

(reviewed ACNPSA 1/20)

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CHIRP Consent Form

The Indiana State Department of Health maintains an electronic immunization registry entitled Children and Hoosiers Immunization Registry Program (CHIRP). CHIRP allows all health care providers within the state of Indiana to enter and view immunization data with this method of electronic documentation. CHIRP ensures that the most up-to-date record of immunizations is available to all health care providers. The Indiana Department of Education mandates that all schools within the state of Indiana utilize CHIRP to document annual immunization reports. We are required to submit these immunization reports to maintain our accreditation. We need your consent via this form to add your child to our school data. The Indiana Department of Education's attorney Dana Long, collaborating with the Indiana State Department of Health, has prepared the consent attached to this document.

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

I understand that my child's information may be available to the immunization data registry of another state, a healthcare provider or a provider's designee, a local health department, an elementary or secondary school, a child care center, the office of Medicaid policy and planning or a contractor of the office of Medicaid policy 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 herby consent to the release of such information.

I, as a parent/legal guardian to the below stated child, give _____ School permission to release in addition to immunization data, the following information concerning my child to the the Indiana State Department of Health's Children and Hoosiers Immunization Registry Program (CHIRP):

_____ _____
Signature Date

_____ _____
Printed Name of Parent(s)/Guardian(s)

_____ _____
Address City, State and Zip Code

_____ _____
Printed Legal Name of Child Birthdate of Child

PLEASE RETURN AT REGISTRATION OR BEFORE FIRST DAY OF SCHOOL

(reviewed ACNPSA 1/20)

Allen County Non Public School Association

HEALTH QUESTIONNAIRE

(Parent/Guardian needs to complete)

Please Print

Student_____Grade_____Date of Birth___/___/___

Address_____

Phone Number_____

Father's name_____Mother's name_____

Student lives with_____

Health History

Check all that apply to your child

ADD/ADHD (circle)
Allergy (specify)
Seasonal _____
Food _____
Other _____
Asthma
Chickenpox
Diabetes
Chronic Ear Infections
Emotional Disorder
GI/GU Issues
Hearing Impairment
Hepatitis
Measles/Mumps/Rubella
Mononucleosis
Physical Handicaps
Pneumonia
Rheumatic Fever
Scarlet Fever
Seizures
Tuberculosis
Vision Impairment
Whooping Cough
____Other_____
____Other_____
____Other_____
____Other_____

Any checks made above, please give explanations and dates of diagnosis:

_____

_____

Has your child had an infectious/communicable disease other than those listed above? Please explain, giving relevant dates:

_____

_____

Does your child require the use of an EPI-PEN for allergic reactions?_____

CONTINUED ON REVERSE

(reviewed ACNPSA 1/20)

Please be specific and include the month/year:

Severe Illnesses: _____

Severe Injuries: (head injury, fractures, etc.): _____

Diagnostic Procedures: _____

Hospitalizations: _____

Surgical Procedures: _____

Is there any other information about your child's health status that you think the school should know which may be relevant to your child's health and safety or the health and safety of others in the school environment?

_____

_____

_____

Please list any condition that should be considered in planning your child's school day:

_____

_____

_____

Physician's Name: _____ Phone # _____

Dentist's Name: _____ Phone # _____

Eye Doctor's Name _____ Phone # _____

To the best of my knowledge the above information is complete and accurate. I acknowledge that I have a continuing obligation to inform the school of any changes in my child's health status that are relevant to the information requested by this form.

_____ _____

Parent/Guardian signature Date

(reviewed ACNPSA 1/20)

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PHYSICIAN CERTIFICATE OF EXAMINATION FORM

(To be completed by your child's physician)

Name_____ Date of Birth___/___/____

Allergies_____

Current Medications

1._____ Dosage_____ Time_____
2._____ Dosage_____ Time_____
3._____ Dosage_____ Time_____

Height_____ **Weight**_____ **B/P**_____ **Pulse**_____

Eyes _____
Ears_____
Nose_____
Throat_____
Chest/Lungs_____
Heart_____
Abdomen_____
Hernia_____
Extremities_____
Musculoskeletal_____
Neurological_____
Skin_____

Lab Work (If indicated)
Hematocrit _____
Hemoglobin _____
Lead Level _____
Sickle Cell _____
Urinalysis _____
Other _____

Tuberculin Test (if indicated)
Type of test_____
Date_____
Results_____

Is this student physically fit to participate in all physical education programs?

Yes_____ No_____ If no, please explain_____

_____

Please list any conditions that should be considered in planning this child's school day:

_____

_____

CONTINUED ON REVERSE

IMMUNIZATION HISTORY

*****PLEASE ATTACH A COPY OF THE CHILD'S FULL*****
IMMUNIZATION RECORD

All students must have an immunization record in the school office before the first day of school. This student MAY NOT attend school without a record of having received the required immunizations listed below. The only exception is to have a medical or religious exemption form filed with the school office.

The following immunizations are the minimum requirement by the State of Indiana for
Kindergarten and 1st Grade

DTaP(5) IPV(4) Hepatitis B(3) MMR(2) Varicella(2) Hepatitis A(2)

2nd -5th Grades

DTaP (5) IPV (4) Hepatitis B (3) MMR (2) Varicella (2)

6th -8th Grades

Previous listed plus an additional Tdap (1) and MCV (1)

(These are the minimum doses that are necessary. All minimum ages and intervals for each vaccination as specified in the CDC guidelines must be followed to be considered valid.)

_____
Printed or Stamped name of the Physician completing this form

_____ _____
Physician's signature **Date**

(rev ACNPSA 1/15)

Allen County Non Public School Association

STUDENT MEDICATION INFORMATION
AND
CONSENT FORM

I have read and understand the medication policies as indicated on the reverse side.

For Prescription Medication(s)

Please administer to **my child (printed name)**_____, the medication as prescribed below by my child's healthcare provider. The label affixed to the medication bottle/package will meet the requirement for the physician's written order.

AND / OR

For Over-The-Counter Medication(s)

Please administer to **my child (printed name)**_____, the medication as described below.

(REMINDER: Prescription and over-the-counter medications must be kept in the original container with the pharmacy or brand label affixed. Medications will only be given as either prescribed by the practitioner or the FDA instructions that are found on the OTC medication label.

NO MODIFICATIONS OF DOSAGE OR FREQUENCY WITHOUT THE WRITTEN CONSENT BY THE CHILD'S HEALTHCARE PROVIDER.

MEDICATION	Dosage amount and/or # of tabs	Time to Be given at school	Date medication is to be discontinued	Reason for medication	Precautions/ Side Effects
1.					
2.					
3.					
4.					

_____ _____

Parent/Guardian Signature Date

FULL MEDICATION POLICY ON REVERSE SIDE

(revised ACNPSA 1/20)