Parent Notice of Immunization and Health Assessment Requirement for Preschool age Students

Student's Name:

Immunizations

Kansas regulations (K.S.A. 72-5208 through 72-5211a) require every pupil enrolling for the first time in a Kansas school to present proof that the pupil has received required immunizations. The Kansas Certificate of Immunization lists immunization requirements based on age and grade level.

Proof of **one each of DTaP, Polio, MMR, Varicella, Hepatitis A, Hepatitis B, PCV (Pneumococcal), and HIB (Haemophilus Influenzae Type B)**, must be presented prior to admission **and then**, according to our district policy, additional boosters received prior to

- the second Monday in October for students enrolled thru August 31,
- the second Monday of January for students enrolled September 1 thru November 30,
- the second Monday of April for students enrolled December 1 thru March 31.

Health Assessment

Kansas regulations also require that preschool age students enrolling for the first time in a Kansas school present proof of a health assessment performed by a physician or another health professional as specified by K.S.A. 72-5214. Ask the school nurse if you would like a list of agencies that provide health assessments. As an alternative to the health assessment a parent may present a written, signed statement indicating religious opposition to health assessments.

According to our district policy, the health assessment may be conducted

- up to 12 months prior to school entry,
- prior to the second Monday in January, or
- a minimum of 90 calendar days from the student's enrollment in school.

Parent/Guardian Signature of Notice _____

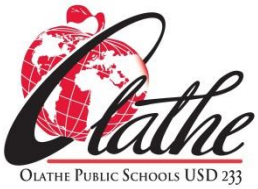
Date _____

Student is transferring from _____ _____ _____
Name of School City State

- -

For school nurse use: Date Student Started School _____

Revised 5/2019



Permission for Release of Immunization Information to Kansas Immunization Registry

The **Kansas Immunization Registry, KSWebIZ**, is a confidential computer system that collects and selectively discloses information to authorized persons about the vaccination history of persons in the State of Kansas.

The purpose of the Kansas Immunization Registry is to consolidate immunization information among health care professionals, assure adequate immunization levels, and to avoid unnecessary immunizations. Access is limited to individuals and entities that either provide immunization services or are required to ensure that persons are immunized. The privacy of participants and the confidentiality of information contained in the registry are protected at all times by all authorized users.

The Olathe School Nurses are users of the KSWebIZ and with parent permission began entering kindergarten and early childhood student records fall of 2010. Johnson County Health Department has implemented the system, and many area health care providers are in the process of becoming users.

Participation in the program is completely voluntary and no other health or educational records will be shared other than school immunization records. If you would like your student's immunization history to be entered into this system, please sign below and return to the school nurse.

Name of Student _____

I give permission for the school immunization record to be released to the Kansas Immunization Program including the immunization registry for the purpose of assessment, reporting, and prevention of disease. I further understand that this consent will remain effective for a) the length of time my student is enrolled in Olathe District Schools or b) until it is revoked by a parent/guardian in writing.

Parent/Guardian Signature _____

Date _____

Revised 1/2013

Olathe District Schools
PK-Elementary Health Intake Information

Today's Date: _____ Grade: _____ Information obtained from: _____
Parent/Guardian

Student's Name: _____ Birth Date: _____ Male ___Female _____
Last First MI

Physician: _____Specialist/Other: _____

Preferred Hospital: _____

Current Medication / Treatment	**Dose**	**Time of day**	**Reason or Diagnosis**

Any development, behavioral, feeding or swallowing concerns? _____
_____
_____

Birth History- PK and Elementary Only

Length of Pregnancy: _weeks **Birth Weight: lb____oz**

Type of Delivery: (circle) **Vaginal** **Planned C-section** **Emergency C-Section**

Did mother have complications during pregnancy, labor or delivery (high blood pressure, toxemia, bleeding, infection, other)? Please specify: _____
_____

Condition of child at birth: _____Normal _____Complications (breathing, heart, NICU stay, other): _____
_____

Any of the following (?): cleft lip/palate, heart murmur, genetic abnormality, club feet, other _____no _____yes (please specify): _____
_____

Speech / Motor Development - PK and Elementary Only

Developmental task (Check)	**Early**	**On Time**	**Delayed**	**Comment/Concern**
Sat Alone				
Crawled				
Walked Alone				
First Words/Sentences				
Toilet Trained				

(see other side)

Medical History

Please check yes or no to all, regarding student's medical history.

History	Yes	No	Comments	Medication
Vision Correction Vision Condition / loss			□ Glasses □ Contact Lenses	
Headaches				
Seizures			Date of last seizure: Type: Date of onset:	
Diabetes			□ Type 1, Insulin-dependent □ Type 2, no insulin needed	
Dizziness/Fainting Holds Breath				
ADD or ADHD				
Ear Infections			□ Currently □ Tubes (x____)	
Hearing Loss			Type: Amplification Used: Cochlear Used:	
Nosebleeds			How often?	
Dental Concerns				
Allergies			Food _____Seasonal __ Insect Stings ___ Medication __ Reaction: Anaphylaxis:	
Asthma			List triggers	
Bronchitis/Pneumonia				
Bladder/Kidney Concerns				
Urinary Tract Infections				
Stomachache (frequent) Ulcers Irritable bowel			Specify:	
Painful bowel movements			How often?	
Sleep Disturbances				
Mental/Emotional/ Behavioral Concerns			□ Anxiety □ Frequently sad Other:	
Cardiac/Heart Concerns				
Hospitalizations /Surgeries			Age/year/reason	
Accidents Head Injury/Concussion			Type of accident/age/year	
Childhood Illnesses				