



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

Student's Name:

## Immunizations

Kansas regulations (K.S.A. 72-6261 through 72-6268) 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. 72-6267. 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

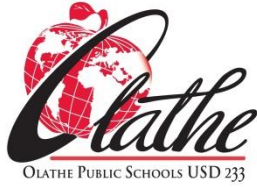
- up to 12 months prior to school entry,
- prior to the second Monday in January, or
- within 90 calendar days of the student's entry to school.

Parent/Guardian Signature of Notice \_\_\_\_\_

Date \_\_\_\_\_

Student is transferring from \_\_\_\_\_  
Name of School City State

For school nurse use: Date Student Started School \_\_\_\_\_



**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 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 \_\_\_\_\_



# Olathe District Schools PK-Elementary Health Intake Information

Today's Date: \_\_\_\_\_ Grade: \_\_\_\_\_ Information obtained from: \_\_\_\_\_

Student's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Gender: \_\_\_\_\_  
Last First MI Parent/Guardian

Physician: \_\_\_\_\_ Specialist/Other: \_\_\_\_\_

Preferred Hospital: \_\_\_\_\_

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

Any development, behavioral, feeding or swallowing concerns? \_\_\_\_\_

If medical history is unknown, check here

### 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	_____	_____	_____	_____

## Medical History

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

History	Yes	No	Comments	Medication
Vision Correction Vision Condition / loss			<input type="checkbox"/> Glasses <input type="checkbox"/> Contact Lenses	
Headaches				
Seizures			Date of last seizure: Type: Date of onset:	
Diabetes			<input type="checkbox"/> Type 1, Insulin-dependent <input type="checkbox"/> Type 2, no insulin needed	
Dizziness/Fainting Holds Breath				
ADD or ADHD				
Ear Infections			<input type="checkbox"/> Currently <input type="checkbox"/> 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			<input type="checkbox"/> Anxiety <input type="checkbox"/> Frequently sad Other:	
Cardiac/Heart Concerns				
Hospitalizations /Surgeries			Age/year/reason	
Accidents  Head Injury/Concussion			Type of accident/age/year	
Childhood Illnesses				