Parent Notice of Immunization and Health Assessment Requirement Grades K - 5

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, IPV, MMR, Hepatitis A, Hepatitis B, and Varicella**, 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.

Kindergarten through 3rd grade Students only - Health Assessment

Kansas regulations require every student up to age nine enrolling for the first time in a Kansas school to 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 from 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 ________________________________

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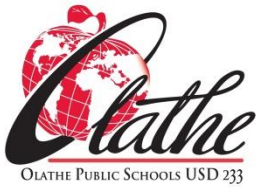

Permission for Release of Immunization Information to Kansas Immunization Registry

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 _____

Revised 1/2021

Olathe District Schools

Health Intake Information

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

Student's Name: _____ Birth Date: _____ Gender: _____
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? _____

_____

_____

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			□ 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				

OTC MED AUTHORIZATION

PARENT CONSENT

Name of Student: _____ Date of Birth: _____ Grade/Teacher: _____

List any known allergies or sensitivities that your child has: _____
_____

School personnel must have signed consent (or online enrollment consent) in order to administer these over-the-counter medications. Generic equivalent medications maintained in the health rooms will be used in place of more expensive brand-name items. The school nurse will administer the approved medications as deemed necessary using his/her nursing judgment. Additionally, the school nurse will attempt to contact you upon administration of medication to your son/daughter.

Over-the-counter medications will be administered sparingly when indicated to make your child more comfortable and able to remain at school. For example, the medication may be used for dental pain, mild headaches, orthopedic pain related to recent injury, or in the case of diphenhydramine for symptoms of an acute allergic reaction. You may still need to be contacted for further care of your child. Also, if your child has a fever (100.0 F or higher), district policy requires that your child go home from school and not return until fever-free for 24 hours without aid of medication.

Check all desired medication(s) for your child. Dosage will be according to weight.

- ☐ Acetaminophen (generic for Tylenol®)
- ☐ Ibuprofen (generic for Advil®)
- ☐ Diphenhydramine (generic for Benadryl®)
- ☐ Cetirizine (generic for Zyrtec®)
- ☐ Tums® antacid (calcium carbonate)

I understand that the school employee who administers these medications according to proper dosages shall not be held liable for any adverse reactions to the medication administered. I hereby give my permission for my son/daughter to receive the above medication(s) checked on this form as deemed necessary by the school nurse.

_____	_____	_____
Parent Signature	Parent (Printed Name)	Today's Date

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