Parent Notice of Immunization

Grades 6 -12

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, Varicella**, **and Meningitis (A,C,W,Y)** 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.

Parent/Guardian Signature of Notice ________________________________

Date ________________________________

Student is transferring from ______________________ ______________ ___________
Name of School City State

- -

For school nurse use: Date Student Started School ______________________

Revised 5/2022

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 ☐

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	
Hearing loss			Type: Amplification Used: Cochlear Used:	
Seizures			Type of Seizure: Date of onset: Date of last seizure:	
ADD or ADHD				
Diabetes			☐ Type 1, Insulin dependent ☐ Type 2, no Insulin needed	
Allergies			Food _______ Seasonal _____ Insect Stings ___ Medication __ Other: ___________________ Reaction: Anaphylaxis:	
Mental/Emotional/ Behavioral Concerns			☐ Anxiety ☐ Frequently sad ☐ Other:	

(Continue)

History	Yes	No	Comments	Medication
Asthma			List triggers:	
Bronchitis/Pneumonia				
Cardiac/Heart Concerns				
Dental Concerns			☐ Need a dentist	
Dizziness/Fainting Holds Breath				
Ear Infections			___Currently ___Tubes (x____)	
Headaches			Frequency:	
Nosebleeds			How often?	
Sleep Disturbances				
Stomachache (frequent) Ulcers Irritable bowel			Specify:	
Tonsillitis (frequent)				
Bladder/Kidney Concern				
Urinary Tract Infections				
Hospitalizations Surgeries			Age/year/reason	
Accidents Head Injury/Concussion			Type of accident/age/year	