# UNION TOWNSHIP SCHOOL CORPORATION
## HEALTH APPRAISAL
Parent or Guardian to complete this side

_____ Birthdate_____ Age_____ Sex_____
Last Name, First, Middle

Address_____ Phone_____ Grade_____

Father_____ Mother_____

**Medical History:** Has child had or presently have – (please mark year and explain below)

| | | |
|---|---|---|
| Polio_____ | Diabetes_____ | Nephritis_____ |
| Chicken pox_____ | Rheumatic Fever_____ | Heart Condition_____ |
| Whooping Cough_____ | Convulsions_____ | Eye problems_____ |
| Scarlet Fever_____ | Strep Throat_____ | Meningitis-type_____ |
| Tuberculosis_____ | Pneumonia_____ | Tonsilitis_____ |

Physical Handicaps (explain)_____

Serious Illness (types and dates)_____

Allergies (list and explain reaction)_____

Asthma (explain)_____

Injuries (types and dates)_____

Surgery (types and dates)_____

Hospitalizations (reasons and dates)_____

Medication (reason and times)_____

Birth Weight_____ Age talking_____ Age walking_____ Right-handed_____ Left-handed_____

**SPEECH, HEARING, AND VISION**
Do you feel your child has a speech problem?_____

Has your child received speech therapy?_____

Has child had treatment for an ear condition?_____ Describe_____

Has child had treatment for eye problems?_____ Describe_____

**BEHAVIOR HISTORY** (Give ages of occurrence)
Has child ever been in a special school or class?_____

Scholastic difficulties or educational problems?_____

Has child ever had any emotional problems? (explain)_____

**Special information about your child:**_____

Consent for participation in PE:_____ Parent/Guardian Signature

## Health Examination

(information on this form may be shared with appropriate personnel for health and educational purposes)

NAME:_____BIRTHDAY_____

IMMUNIZATIONS: Must be documented by the first day of school. Provide month, day, year

**DPT/DT/Td** 1_____2_____3_____4_____5_____

**POLIO (IPV/OPV)** 1_____2_____3_____4_____5_____

**MMR** 1_____2_____ **Varicella** 1_____2_____

**Measles**

**Mumps** **TB test date**_____ **TB results**_____

**Rubella**

**HEPATITIS B** 1_____2_____3_____

**HEPATITIS A** 1_____2_____

Immunization Verification by_____M.D. or

Health Department Official_____

**Physical Examination: To be completed by a Physician**

| | NORMAL | ABNORMAL | COMMENT |
|---|---|---|---|
| SKIN | | | |
| EYES | | | |
| EARS | | | |
| NOSE | | | |
| THROAT | | | |
| DENTAL | | | |
| HEART | | | |
| LUNGS | | | |
| GASTROINTESTINAL | | | |
| GENITO-URINARY | | | |
| NEUROLOGICAL | | | |
| MUSCULAR-SKELETAL | | | |
| EMOTIONAL STATUS | | | |

HEIGHT_____WEIGHT_____B/P_____

| TESTING | DATE | NORMAL | ABNORMAL RESULTS |
|---|---|---|---|
| URINALYSIS | | | |
| VISION | | | |
| HEARING | | | |
| SCOLIOSIS | | | |

MEDICATIONS_____

ALLERGIES_____

DIET RESTRICTIONS/NEEDS_____

SPECIAL EQUIPMENT NEEDS_____

OTHER NEEDS OR GENERAL COMMENTS_____

On the basis of this examination, I approve this child's participation for one year in Physical Education.

Yes___No___PHYSICIAN'S SIGNATURE_____DATE_____

# UNION TOWNSHIP SCHOOL CORPORATION

MR. JOHN HUNTER, ED. S.
SUPERINTENDENT

MR. MICHAEL STEPHENS, ED. S.
ASSISTANT SUPERINTENDENT

599 W 300 N, SUITE A
VALPARAISO, IN 46385
PHONE: (219) 759-2531 • FAX: (219) 759-3250
"WHAT'S BEST FOR KIDS"


I, _____, give Union Township School Corporation, permission to release the following information concerning my child_____ to the Indiana State Department of Health's Children and Hoosiers Immunization Registry Program (CHIRP):

Name
Birthdate
Address
Immunization information

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 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 and 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 hereby consent to the release of such information.

_____ _____
Signature Date

_____
Printed Name of Parent or Guardian

_____ _____
Address Telephone Number

_____ _____
Child's Name Grade Level

_____
School

UNION TOWNSHIP SCHOOL CORPORATION

## MEDICATION CONSENT

According to Indiana P.L. 219 the Parent Authorization form must be completed before any medication can be administered.

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## PRESCRIPTION MEDICATION

Medication will only be given to a student provided the written authorization of the Doctor and Parent or Guardian is on file. The Pharmacy label on the prescription serves as written authorization by the Doctor.

**Name**_____

**Medication**_____

**Dosage and Fequency of Administration**_____

**Physician's Signature** _____ **Date** _____

## PARENT AUTHORIZATION

I authorize the building principal or his designee at my child's school to administer medication to my child. *In the case on nonprescription medication the dosage requested must not exceed the manufacturer's recommendation.*

**Name**_____

**Medication**_____

**Dosage and Frequency of Administration**_____

**I understand that I will be responsible for supplying the medication to the school.** I further understand that this authorization is valid for the duration of each such illness and that in the case of a chronic condition the authorization will be valid for the duration of the school year.

**Parent Signature**_____ **Date** _____

**8/24/05**

# MEDICATION

In an effort to ensure student health and safety it is necessary to remind parents of the Union Township Schools Medication Policy.

**PRESCRIPTION MEDICATION** may only be given to students provided the following is on file at the school:

1) Written permission and authorization signed by the student's parent or guardian stating the student's name, medication, dosage, when it is to be administered, and reason for giving the medication.

2) Written instructions from the student's physician, or typed instructions on the prescription bottle.

**NONPRESCRIPTION MEDICATION** will be administered at school provided:

1) Medication is sent to school in the original container.

2) Written permission signed by the student's parent or guardians stating the student's name, medication, dosage (provided the request does not exceed the manufacturer's recommendations), and reason for giving the medication.

All medication must be dispensed from the Health Office. Students must not carry any medication in purses, backpacks, pockets, lockers, etc.

Those students with asthma may carry their own inhalers with written authorization from Parent/Physician that includes: Name of student, medication, dosage, time, the intent for student to carry the medication, and ability of student to self-medicate.

Medication equipment and drug supplies will be accepted by the school nurse only from a parent or guardian.

**UNION TOWNSHIP SCHOOL CORPORATION**

**HEALTH SERVICES**

Dear Parents,

Congratulations on becoming "Kindergarten Parents" and welcome to Union Township Schools. Kindergarten is a big step for your child, as well as for you as parents. In order to help your child get off to a healthy start, we have compiled the following information that we hope will be useful to you as a kindergarten parent.

I. The Indiana State Board of Health requires that all children entering kindergarten meet the following immunization requirements:

| | |
|---|---|
| DTP/Dtap or DT | **5 Doses** |
| Polio | **4 Doses** |
| Hepatitis B | **3 Doses** |
| MMR (Measles, Mumps, Rubella) | **2 Doses** |
| Varicella (chickenpox) | **2 Doses, or** physician **documentation of disease history** |
| Hepatitis A | **2 Doses** |

**IMMUNIZATIONS MUST BE COMPLETED BY THE FIRST DAY OF SCHOOL**

II. HEALTH AND DENTAL EXAMINATIONS:

A health examination by your family physician as well as a dental examination by a dentist are important to your child's overall health. It is recommended that your child be examined before entering school and periodically thereafter.

III. EXCLUSION FROM SCHOOL:

Your child will come in close contact with other children every day while at school. You can help us keep our school system healthy by observing your child for any symptoms of common childhood diseases or illness. When your child shows any signs of illness, please keep them home. Symptoms to watch for are a sore throat, flushed face, headache, fever, skin rash, runny or congested nose, frequent cough or sneezing, vomiting or other signs of illness.

It is the school health policy to **EXCLUDE FROM SCHOOL** any child who has:

1. A temperature of 100 degrees or over.

2. Any inflammatory eye condition (such as pink eye).

3. Any cough associated with fever or continuous unrelieved coughing.

4. Colds, if associated with other signs or symptoms of illness.

5. Sore or inflamed throat.

6. Drainage from the ears.

7. Head lice (pediculosis) – children are excluded until they are free of all lice and nits. They must be checked by the school nurse before returning to the classroom.

8. Any other infestations: Scabies, fleas, etc.

9. Skin diseases and rashes.
   - Exclude until diagnosed by physician as non-contagious.
   - Exclude until properly treated as prescribed by a physician.
   - Exclude if discomfort is great and non-contagious, (poison ivy).

10. Diarrhea

11. Vomiting

## IV. ABSENCES

When a child has been absent from school due to an illness, the child may return to school when he or she has had a normal temperature for 24 hours without fever reducing medication, is symptom free, or has been on prescribed antibiotic therapy for 24 hours. Please call the school concerning any absences.

Should you have any questions or concerns, please feel free to contact us. We look forward to being a part of your child's educational experience.

Julie Burian RN, BSN
UCE School Nurse