KINDERGARTEN CHECKLIST

Dear Parent/Guardian of Incoming Kindergartener:

The following health forms are needed **PRIOR** to your student starting school.

- ❑ **Physical** – A physical exam must be completed by a healthcare care provider and a copy provided to the school. This is not required for kindergarten, but **highly recommended.** If you did not provide one the previous year or did not attend preschool here.

- ❑ **Immunization Record - Required by state law; all immunizations are completed for age by the first day of school. If immunizations are not up to date, children can be denied enrollment.** I recommend you obtain a copy of this from your child's physician at the time of their physical.

- ❑ **Dental Screening – Required**: No earlier than age 3 and no later than 4 months after enrollment. **Form provided.**

- ❑ **Vision Screening – Required:** The vision screening can be performed by an ophthalmologist, optometrist, physician, free clinic, child care center, local public health department, community based organization, or ARNP.
  -There are two forms: either one will work. In accordance with Senate File 2251, we have to include the Student Vision Card. According to the Iowa Department of Public Health, we have to give their form too. EITHER FORM IS ACCEPTABLE, and you only need to do one.

- ❑ **Lead Testing - Required** for all incoming Kindergarten students to have had at least one lead test prior to age 6. No form needed, please just verify your child has had this done.

- ❑ **Medication Forms**- There are *two* medication forms included. Please fill out the Over the Counter (OTC) Medication form if your student is allowed OTC medications at school. If your child needs to take a prescription medication, please fill out a prescription medication form. This does require a primary care provider's signature.

- ❑ **Diet Restriction Form-** If your child has a diet restriction, it is required by the USDA that we have a form on file. This form does require primary care providers signature. If you need this form, please call or email.

Please feel free to contact me with any questions or concerns. Records can be dropped off, mailed, or faxed. Forms can also be found on our school website:

Quinn Baudler, RN : AC Elementary & AC/GC JH School Nurse
3384 Indigo Ave., Adair, IA 50002: Phone: 641-742-3310/641-746-224 : Fax: 641-746-2243

Lindsay Fluharty : GC Elementary & ACGC HS Nurse
900 N. 4th Street, Guthrie Center, IA 50115 : Phone 641-332-2720 : FAX 641-332-2721

ACGC Community School District Physical Exam Form

Student Name:_____DOB:_____

Height:	Weight:	BP/Vitals:	Lead:	Hgb:	Vision: L: R:	

	Normal	Abnormal	Not Examined	Description
General Appearance Posture and Gait				
Behavior				
Skin				
Eyes				
Ears				
Nose, Throat, Mouth, Pharynx, Tonsil				
Teeth				
Heart:				
Lungs				
Abdomen				
Genitalia				
Extremities & Feet				
Neurological				
Other				

Disability (diagnosis):	Treatment:

Summary of findings and/or recommendations: _____

_____

Signature of Provider_____ Date:_____

FacilityStamp:

ACGC Schools Parental OTC Medication Form

Students Name:_____Grade: _____

Parental Order From for Over-the Counter Medications

The school nurse/certified medication aide will have the following over-the-counter (OTC) available to students according to written protocol by the school and with written parental authorization to administer OTC medication. Please check medications your child may receive for minor health complaints such as cold, menstrual cramps, headache, sore throat, sore muscles, backache, eye irritation, burns, sprains, upper respiratory infections, nasal congestion, upset stomach, diarrhea, and rashes. A record of administration will be maintained by administering staff.

Check one:

- ❏ May give all medications list
- ❏ DO NOT give any medications
- ❏ Give ONLY medications checked:
- ❏ Acetaminophen (Tylenol) 325mg/500mg, 1-2 tablets every 4 hours
- ❏ Children's Acetaminophen (Tylenol) chewables and liquid suspension as directed per age/weight
- ❏ Benadryl as directed for allergic reactions (after parent notified)
- ❏ Tums 1-2 tablets, upset stomach, heartburn
- ❏ Antibiotic Ointment, cuts, abrasions, wounds, burns, etc.
- ❏ Hydrogen Peroxide
- ❏ Cough Drops: 1-2 cough drop for sore throat, irritation, cough
- ❏ Other _____

I verify that the student has experienced no previous side effects from these medications. Parent/guardian will be notified if frequent requests for any of the above medication occur: If a student is requiring or has been ordered frequent dosing of any of the above medication, a doctor's note may be requested as well as the parent will be required to supply such medication.

I give permission for the school nurse/trained personnel to perform routine health screenings that may include: hearing, vision, dental, height, and weight. Parent/Guardian will be contacted with abnormal results. The school has permission to provide first aid treatment for medical/dental issues.

_____

Parent/Guardian Signature Date

Please return this form to the school nurse by the first day of school! *No OTC medication will be administered to your child unless this form is completed and signed. ** Per the IA Board of Nursing, no essential oils/natural remedies/supplements are allowed to be administered to school children

ACGC Schools Medication Request

Prescription Drugs- must be sent in the original bottle with prescription intact, with name of student, name and strength of drug, amount and time to be given, date ordered (must be current), and name of doctor. Prescription medication also requires written and dated authorization from a parent/guardian and a prescribing doctor. Please see the form below.

\- -

Request for Medication Administration at School

Student Name____DOB___________

Medication Name____Strength____________

Dose to be Given____

Time to be Given____

Dates to be Given____

Why does this student need this medication______________________________________

____

Physician Name and Signature Date

I absolve the Adair-Casey Community Schools, and the person administering the medication, of all liability in giving this medication, providing directions are carefully followed. By signing this you are giving the Health Staff permission to discuss this medication with student's teachers, staff, and doctor.

____

Parent Signature Date

Iowa Department of Public Health
CERTIFICATE OF DENTAL SCREENING

This certificate is not valid unless all fields are complete.
RETURN COMPLETED FORM TO CHILD'S SCHOOL.

Student Information (please print)

Student Last Name:	Student First Name:	Birth Date (M/D/YYYY):
Parent or Guardian Name:	Telephone (home or mobile):	
Street Address:	City:	County:
Name of Elementary or High School:	Grade Level:	Gender: ☐ Male ☐ Female

Screening Information (health care provider must complete this section)

Date of Dental Screening: _____

Treatment Needs (check ONE only based on screening results, prior to treatment services provided):

☐ **No Obvious Problems** – the child's hard and soft tissues appear to be visually healthy and there is no apparent reason for the child to be seen before the next routine dental checkup.

☐ **Requires Dental Care** – tooth decay[1] or a white spot lesion[2] is suspected in one or more teeth, or gum infection[3] is suspected.

☐ **Requires Urgent Dental Care** – obvious tooth decay[1] is present in one or more teeth, there is evidence of injury or severe infection, or the child is experiencing pain.

[1] Tooth decay: A visible cavity or hole in a tooth with brown or black coloration, or a retained root.
[2] White spot lesion: A demineralized area of a tooth, usually appearing as a chalky, white spot or white line near the gumline. A white spot lesion is considered an early indicator of tooth decay, especially in primary (baby) teeth.
[3] Gum infection: Gum (gingival) tissue is red, bleeding, or swollen.

Screening Provider (check ONE only):
☐ DDS/DMD ☐ RDH ☐ MD/DO ☐ PA ☐ RN/ARNP (High school screen must be provided by DDS/DMD or RDH)

Provider Name: (please print) _____ Phone: _____

Provider Business Address: _____

Signature and Credentials of Provider or Recorder*: _____ Date: _____

*Recorder: An authorized provider (DDS/DMD, RDH, MD/DO, PA, or RN/ARNP) may transfer information onto this form from another health document. The other health document should be attached to this form.

A screening does not replace an exam by a dentist.
Children should have a complete examination by a dentist at least once a year.
RETURN COMPLETED FORM TO CHILD'S SCHOOL.

Iowa Department of Public Health • Oral Health Center
515-242-6383 • 866-528-4020 • http://idph.iowa.gov/ohds/oral-health-center
A designee of the local board of health or Iowa Department of Public Health may review this certificate for survey purposes.

8/17/2016

AC/GC Illness Policy and Exclusion of Sick Kids

For the health and safety of all the children, it is mandatory that sick children not be brought to school. If your child has any of the following symptoms during the night, he or she will not be admitted the following morning for the safety of the other children.

- Fever greater than 100 degrees F
- Vomiting
- Diarrhea
- Pink eyes with drainage
- Cough with congestion and excessive nasal discharge

The center's established policy for an ill child's return:

- Fever free for 24 hours without use of fever reducing medication.
- Chicken pox: one week after onset (or when lesions are crusted)
- Strep: 24 hours after initial medication dose
- Vomiting/Diarrhea: 24 hours after last episode
- Conjunctivitis (Pink Eye): 24 hours after initial medication dose or when without drainage