Lakeview Elementarty
111 N. Chabal Street, Solon, Iowa 52333
www.solon.k12.ia.us • (319) 624-3401 • fax (319) 624-4176

Solon Community Schools Pre-Kindergarten Physical Form

Name: ______________________ Parent: ______________________

Age: ________ Date of Birth: ________________ Sex: ____________

Height: ______________ Weight: ______________

Blood Pressure: __________ Allergies: ______________

For the following , √ = normal; describe impairments

Skin: ____________ Ears: ____________

Eyes: ____________ Nose/Throat/Tonsils: ________

Lungs: ____________ Heart: ____________

Abdomen: ____________ Genitalia: ____________

Bowel Pattern: __________ Urination: ____________

Extremities: ____________ Reflexes: ____________

Coordination: ____________ Balance: ____________

Did you recommend a referral? (ENT, Eye, Ortho, Urology, ect.) Yes___ No___
If yes, what kind? ____

Recommendations and Comments:

____

____

____

Iowa code section 135.39D establishes a vision screening requirement for all children enrolled in a public elementary school.
Vision Screening: right eye_______ left eye _______ both eyes _______

House File 158 of Iowa Law mandates that each child be screened for lead levels before entering Kindergarten. Was this child tested for lead? Yes _____ No _____
Date of screening(s) ______________________ Screening Clinic ______________

Does this child have an Iowa Department of Public Health Immunization filled out and up to date?
Yes____ No____ If no, explain: ______________________
***Please send a completed copy of immunizations with the child for Kindergarten enrollment**

Signature: ______________________ Date: ______________(Physician, Physician's Assistant, or Nurse Practitioner)

Iowa Department of Public Health
Certificate of Immunization

Name Last: ____________________ First: ____________ Middle: ____________ Date of Birth: ____________

Parent/Guardian: ____________ Address: ______________________________ Phone: (____)____________

I certify that the above named applicant has a record of age-appropriate immunizations that meet the requirement for licensed child care or school enrollment.

Signature: ______________________________ Date: ____________

Physician, Physician Assistant, Nurse, or Certified Medical Assistant

A representative of the local Board of Health or Iowa Department of Public Health may review this certificate for survey purposes.

	Vaccine	Date Given	Doctor / Clinic / Source
Diphtheria, Tetanus, Pertussis DTaP/DTP/DT/ Td/Tdap			
Polio IPV/OPV			
Measles, Mumps, Rubella MMR			
***Haemophilus influenzae* type b** Hib			
Hepatitis B			

	Vaccine	Date Given	Doctor / Clinic / Source
Varicella Chicken Pox If patient has a history of natural disease write "Immune to Varicella"			
Pneumococcal PCV/PPV			
Meningococcal MCV4/MPSV4			
Hepatitis A			
Rotavirus			
Human Papilloma Virus HPV			
Other			

IMMUNIZATION REQUIREMENTS

Applicants enrolled or attempting to enroll shall have received the following vaccines in accordance with the doses and age requirements listed below. If, at any time, the age of the child is between the listed ages, the child must have received the number of doses in the "Total Doses Required" column.

Institution	Age	Vaccine	Total Doses Required
Licensed Child Care Center	Less than 4 months of age	This is not a recommended administration schedule, but contains the minimum requirements for participation in licensed child care. **Routine vaccination begins at 2 months of age.**	
	4 months through 5 months of age	Diphtheria/Tetanus/Pertussis	1 dose
		Polio	1 dose
		haemophilus influenzae type B	1 dose
		Pneumococcal	1 dose
	6 months through 11 months of age	Diphtheria/Tetanus/Pertussis	2 doses
		Polio	2 doses
		haemophilus influenzae type B	2 doses
		Pneumococcal	2 doses
	12 months through 18 months of age	Diphtheria/Tetanus/Pertussis	3 doses
		Polio	2 doses
		haemophilus influenzae type B	2 doses; or 1 dose received when the applicant is 15 months of age or older.
		Pneumococcal	3 doses if the applicant received 1 or 2 doses before 12 months of age; or 2 doses if the applicant has not received any previous doses or has received 1 dose on or after 12 months of age.
	19 months through 23 months of age	Diphtheria/Tetanus/Pertussis	4 doses
		Polio	3 doses
		haemophilus influenzae type B	3 doses, with the final dose in the series received on or after 12 months of age, or 1 dose received when the applicant is 15 months of age or older.
		Pneumococcal	4 doses; or 3 doses if the applicant received 1 or 2 doses before 12 months of age; or 2 doses if the applicant has not received any previous doses or has received 1 dose on or after 12 months of age.
		Measles/Rubella[1]	1 dose of measles/rubella-containing vaccine received on or after 12 months of age; or the applicant demonstrates a positive antibody test for measles and rubella from a U.S. laboratory.
		Varicella	1 dose received on or after 12 months of age if the applicant was born on or after September 15, 1997, unless the applicant has had a reliable history of natural disease.
	24 months and older	Diphtheria/Tetanus/Pertussis	4 doses
		Polio	3 doses
		haemophilus influenzae type B	3 doses, with the final dose in the series received on or after 12 months of age; or 1 dose received when the applicant is 15 months of age or older. Hib vaccine is not indicated for persons 60 months of age or older.
		Pneumococcal	4 doses if the applicant received 3 doses before 12 months of age; or 3 doses if the applicant received 2 doses before 12 months of age; or 2 doses if the applicant received 1 dose before 12 months of age or received 1 dose between 12 and 23 months of age; or 1 dose if no doses had been received prior to 24 months of age. **Pneumococcal vaccine is not indicated for persons 60 months of age or older.**
		Measles/Rubella[1]	1 dose of measles/rubella-containing vaccine received on or after 12 months of age; or the applicant demonstrates a positive antibody test for measles and rubella from a U.S. laboratory.
		Varicella	1 dose received on or after 12 months of age if the applicant was born on or after September 15, 1997, unless the applicant has had a reliable history of natural disease.
Elementary or Secondary School (K-12)	4 years of age and older	Diphtheria/Tetanus/Pertussis[4, 5]	3 doses, with at least 1 dose of diphtheria/tetanus/pertussis-containing vaccine received on or after 4 years of age if the applicant was born on or before September 15, 2000[2]; or 4 doses, with at least 1 dose of diphtheria/tetanus/pertussis-containing vaccine received on or after 4 years of age if the applicant was born after September 15, 2000, but before September 15, 2003[2]; or 5 doses with at least 1 dose of diphtheria/tetanus/pertussis-containing vaccine received on or after 4 years of age if the applicant was born on or after September 15, 2003[2, 3]; and 1 time dose of tetanus/ diphtheria/acellular pertussis-containing vaccine (Tdap) for applicants in grades 7 and above, if born on or after September 15, 2000; regardless of the interval since the last tetanus/diphtheria containing vaccine.
		Polio[7]	3 doses, with at least 1 dose received on or after 4 years of age if the applicant was born on or before September 15, 2003; or 4 doses, with at least 1 dose received on or after 4 years of age if the applicant was born after September 15, 2003.[6]
		Measles/Rubella[1]	2 doses of measles/rubella-containing vaccine; the first dose shall have been received on or after 12 months of age; the second dose shall have been received no less than 28 days after the first dose; or the applicant demonstrates a positive antibody test for measles and rubella from a U.S. laboratory.
		Hepatitis B	3 doses if the applicant was born on or after July 1, 1994.
		Varicella	1 dose received on or after 12 months of age if the applicant was born on or after September 15, 1997, but born before September 15, 2003, unless the applicant has had a reliable history of natural disease; or 2 doses received on or after 12 months of age if the applicant was born on or after September 15, 2003, unless the applicant has a reliable history of natural disease.[8]

[1] Mumps vaccine may be included in measles/rubella-containing vaccine.

[2] DTaP is not indicated for persons 7 years of age or older, therefore, a tetanus-and diphtheria-containing vaccine should be used.

[3] The 5th dose of DTaP is not necessary if the 4th dose was administered on or after 4 years of age.

[4] Applicants 7 through 18 years of age who received their 1st dose of diphtheria/tetanus/pertussis-containing vaccine before 12 months of age should receive a total of 4 doses, with one of those doses administered on or after 4 years of age

[5] Applicants 7 through 18 years of age who received their 1st dose of diphtheria/tetanus/pertussis-containing vaccine at 12 months of age or older should receive a total of 3 doses, with one of those doses administered on or after 4 years of age.

[6] If an applicant received an all-inactivated poliovirus (IPV) or all-oral poliovirus (OPV) series, a 4th dose is not necessary if the 3rd dose was administered on or after 4 years of age.

[7] If both OPV and IPV were administered as part of the series, a total of 4 doses are required, regardless of the applicant's current age.

[8] Administer 2 doses of varicella vaccine, at least 3 months apart, to applicants less than 13 years of age. Do not repeat the 2nd dose if administered 28 days or greater from the 1st dose. Administer 2 doses of varicella vaccine to applicants 13 years of age or older at least 4 weeks apart. The minimum interval between the 1st and 2nd dose of varicella for an applicant 13 years of age or older is 28 days.

Iowa Department of Public Health
Promoting and Protecting the Health of Iowans

Thomas Newton, MPP, REHS Director	Chester J. Culver Governor	Patty Judge Lt. Governor

BLOOD LEAD TESTING REQUIRED BEFORE SCHOOL ENTRY

Do Iowa children need to have a blood lead test before they start kindergarten?

Yes, beginning in the fall of 2008, all Iowa children must have proof of a blood lead test before starting kindergarten, or as soon after that as the parents are notified that the child needs a test.

My child was already tested for lead poisoning at the age of 2 years. Is another test needed? Do I need to take a copy of my child's blood lead test to the school?

No, if the Iowa Department of Public Health (IDPH) has a record of the test, your child does not need another test. (Physicians and laboratories report all tests to IDPH.) IDPH will let you and the school know if they do not have a record of the test.

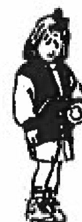
Will Medicaid, hawk-i, or private insurance cover the cost of a blood lead test?

Medicaid and *hawk-i* will both pay for a blood lead test. Many insurance plans also pay for this test. If you do not have a way to pay for this test, the Iowa Department of Public Health will have some funds to pay for it.

Is there a religious exemption for the blood lead testing requirement?

Yes, there is a religious exemption. There is a form that you must fill out and have notarized. You need to file this form with the school. The form will soon be available from the Iowa Department of Public Health, schools, and local health departments.

Will my child be kept out of school if they have not had a blood lead test?



Your child will not be kept out of school. However, childhood lead poisoning is a serious problem in Iowa. It causes learning disabilities and could affect your child's school performance, so we strongly recommend that your child be tested for lead poisoning.

Lucas State Office Building 321 E 12th Street Des Moines IA 50319-0075 ■ 515-281-7689 ■ www.idph.state.ia.us

OTHER INFORMATION ABOUT CHILDHOOD LEAD POISONING

How often should your child be tested for lead poisoning?

It's important to get their blood lead level tested at least once a year until they are six years old. Many children have normal blood lead levels at 6-12 months of age. However, these same children may become lead-poisoned when they are older and more active.

How do children become lead-poisoned?

Children become lead-poisoned if they:

- Put lead-based paint chips in their mouths.
- Put dusty or dirty hands, toys, bottles, or pacifiers in their mouths.
- Chew on surfaces painted with lead-based paint.
- Play in dirt or a sandbox near an old building or where an old building was torn down.
- Breathe in dust from lead-based paint that is being sanded, scraped, or removed with a heat gun.

Lead poisoning is usually caused by lead-based paint found in homes built before 1960. About 60% of the homes in Iowa, both in urban and rural areas, were built before 1960.

How common is lead poisoning?

Lead poisoning affects 1 in 14 Iowa children. This is four times the national average.

Could your child be lead-poisoned?

Yes — most children with lead poisoning do not look sick. Lead-poisoned children may:

- Be easily excited.
- Have problems paying attention.
- Complain of stomach aches and headaches.
- Be more tired than usual.

Lead-poisoned children may have learning problems when they start school. Children with very high lead levels may have severe brain damage or even die. The only way to tell if your child is lead-poisoned is to have their blood tested.

Where can I get more information?

For more information about lead poisoning and how you can protect your children, contact one of the following agencies:

Iowa Department of Public Health
1 (800) 972-2026
(515) 281-3479
or your local city or county
health department or housing agency

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.

Iowa Department of Public Health
CERTIFICATE OF VISION SCREENING

RETURN COMPLETED FORM TO CHILD'S SCHOOL.

Student Information (please print)

Student Last Name:	Student First Name:	Birth Date (M/D/YYYY):
Parent/Guardian Telephone Number:	Student Address:	
Zip Code:		

Screening Information (vision screening provider must complete this section *or parents may attach a copy of vision screening results given to them by a provider.*)

Date of Vision Screening: ____________________

Results (visual acuity):

Right Eye__________ Left Eye__________

Overall Result (Please select one):

Pass ○ or Fail ○

Referral to eye health professional (Please select one):

Yes ○ or No ○

Screening Provider: ____________________

Provider Business Name/Source of Screening: (please print) ____________________

Provider Name: (please print) ____________________ Phone: __________

Signature and Credentials of Provider: ____________________ Date: __________

A parent or guardian of a child who is to be enrolled in a public or accredited nonpublic elementary school shall ensure the child is screened for vision impairment at least once before enrollment in Kindergarten **and** again before enrollment in the 3rd grade.

To be valid, a minimum of one child vision screening shall be performed no earlier than one year prior to the date of enrollment in Kindergarten and no later than six months after the date of the child's enrollment in Kindergarten.
To be valid, a minimum of one child vision screening shall be performed no earlier than one year prior to the date of enrollment in 3rd grade and no later than six months after the date of the child's enrollment in 3rd grade.

RETURN COMPLETED FORM TO CHILD'S SCHOOL.

Iowa Department of Public Health • Bureau of Family Health
FAX 515-242-6013 • 866-383-3826 • www.idph.state.ia.us