Dear Parent of a Preschool Student,

I am looking forward to working with your student in the upcoming school year. Please provide the items listed below today or as soon as possible. They are due no later than the first day of school:

1. **An up-to-date copy of your child's immunization record.** Your child must have the following vaccines in the corresponding number of doses to attend school and to comply with Kansas immunization regulations.

   4 doses- DTaP or DPT (diphtheria, tetanus, whooping cough)

   3 doses- OPV or IPV (polio)

   1 dose- MMR (measles, mumps, rubella)

   1dose- Varicella (chicken pox)

   3 doses- Hep B (Hepatitis B)

   2 doses- Hep A (Hepatitis A)

   4 doses- Hib (Haemophilis Influenza type B)

   4 doses- PCV 7 (Pneumococcal Conjugate)

2. A **physical examination form completed by a physician or nurse** certified to perform physicals. The physical must be completed any time within 12 months prior to school entry.

3. **A completed "New Elementary Student Health History" form.**

If you have any questions and/or need to speak with me directly regarding your child's health concerns please call 620-488-2617 or e-mail me at rlawless@usd357.org.

Sincerely,

Rigaile Lawless, RN
USD #357 School Nurse

CCL 029a
Rev. 3/2017

Child Health Assessment

The Child Health Assessment form is to be completed and signed by a nurse approved by KDHE to perform Child Health Assessments or a Licensed Physician. If a Physician Assistant (PA) completes the Child Health Assessment, the signature of the Licensed Physician authorizing the PA is to be included at the bottom of this form.

A Child Health Assessment, recorded on a KDHE Form or other acceptable Forms mentioned below, is required for all children including children of the provider or staff in Licensed Day Care Homes, Group Day Care Homes, Child Care Centers and Preschools. A Kan-Be-Healthy Assessment Form is a KDHE Form and is acceptable, a Physician Health Assessment Form is acceptable, and a School Health Assessment Form is acceptable for school-age children or youth. The Health Assessment Form used should be attached to the KDHE Medical Record Form (CCL. 029).

Child's Name_____ **Date of Birth**_____
First Last

Health history and medical information pertinent to routine child care and emergencies (describe, if any): ☐ None	Do you see this child for regular health supervision: ☐ Yes ☐ No
Allergies to food or medicine (describe, if any): ☐ None	
List current medications (if any): ☐ None	

Length/Height: ____ **IN/CM** **%ILE** ____		**Weight:** ____ **LB/KB** **%ILE** ____
Physical Examination	✓ **If Normal**	**If Abnormal - Comments**
Head/Ears/Eyes/Nose/Throat		
Teeth		
Cardio/Respiratory		
Abdomen/GI		
Genitalia/Breasts		
Extremities/Joints/Back/Chest		
Skin/Lymph Nodes		
Neurologic & Developmental		
Screening Tests	**Screening Date**	**Note Here if Results are Pending or Abnormal**
Lead		
Anemia (HGB/HCT)		
Urinalysis (UA)		
Hearing		
Vision		

Health Problems or Special Needs, Recommended Treatment/Medications/Special Care (Attach additional sheets if necessary)
☐ None

Signature of Licensed Physician or Nurse approved for Child Health Assessments	Date
Print the Name of the Individual Signing Above	Phone Number
Address City	Zip Code

History of Immunizations

Required for all children in child care facilities, including the provider's own children. A Kansas Certificate of Immunizations (KCI) may be substituted for this form and attached to the completed Medical Record.

Child's Name:_____ **Date of Birth:** _____

First Last MM/DD/YYYY

Section I. For a recommended schedule of immunizations, refer to the current schedule published by the Advisory Committee on Immunization Practices (ACIP).

Vaccine	Record the Month. Day and Year that each Dose of Vaccine was Received					
	1st	2nd	3rd	4th	5th	6th
Diphtheria, Tetanus, Pertussis (DTaP)						
Poliomyelitis (IPV/OPV)						
Measles, Mumps, Rubella (MMR)						
Hepatitis B (HepB)						
Varicella (VAR)			Hx of Disease: Physician Signature		Date of Illness:	
Hemophilus Influenzae Type B (Hib)						
Pneumococcal Conjugate (PCV)						
Hepatitis A (HepA)						
Rotavirus **Recommended <8 mo of age; not required						
Influenza(Flu) ** Recommended annually >6 mo of age; not required						

Section II.
Complete this section only if your child is exempted from the law requiring immunizations [K.S.A. 65-508(d)].

The following two options are the **ONLY** exemptions allowed by law. **Please check either (A) or (B) below and complete as required:**

☐ **(A) Certification from licensed physician stating that immunization would endanger child's life:**
Exempt from following immunizations:

____DTaP/DT ____Tdap/TD ____Pertussis Only ____Polio ____MMR ____HepA ____HepB ____Hib
____PCV ____Varicella ____Other

Physician's Signature (required): _____ **Date:** _____

☐ **(B) My child is exempt under the law from immunizations. As the Parent or Legal Guardian, I state that I am an adherent of a religious denomination whose teachings are opposed to immunizations.**

Section III.

Parent/Guardian Signature:_____ **Date:** _____