

March 30, 2006

Dear Parents:

Pre-enrollment application for students entering district pre-schools in the fall is requested at each attendance center by May 1, 2006.

Please bring or send the following items:

- 1.) Your child's birth certificate
- 2.) Immunization records
- 3.) Early childhood application form
- 4.) A physical which was done by a medical professional by August 2006.

Remember to request a screening appointment if you have any questions regarding your child's hearing, vision, speech or language skills or motor skills.

Parents will have an opportunity to talk with and ask questions of the pre-school teachers, principal, special services staff, school nurse and the school secretary at a pre-school get acquainted meeting this summer.

Please call your school secretary if you have questions.

PHYSICAL EXAMINATION: To be completed by health care provider approved to perform health assessments.

Height: _____ Weight: _____ Hgb or Hct: _____
 Pulse: _____ Blood Pressure: _____ Lead _____
 Urinalysis: _____ Sickle Cell: _____ Other _____
 Tuberculosis: _____ Head Circumference: _____

Code each item as follows: 0 = No significant findings 1 = significant findings	Code	Description of Findings
General appearance		
Integument		
Head - neck		
EENT		
Oral - dental		
Thorax		
Breasts		
Cardiovascular		
Abdomen		
Musculoskeletal		
Genitourinary		
Neurological		

SCREENING

1. Nutritional evaluation (all ages - each screen) (* if applicable). Nutrition/WIC questionnaires available from 785-296-0092.
 • Enrolled in WIC • Receiving vitamin supplement with iron • Without iron • Fluoride supplement

Food intake review. Results:

milk/milk products (breast fed/type of formula) _____
 fruit/vegetables _____
 Meat, beans, eggs _____
 breads, cereals _____

2. Development: Type of screen _____ Results: _____
 3. Speech: Type of screen _____ Results: _____
 4. Hearing: Type of screen _____ Results: _____ Date last screen: _____
 5. Vision: Type of screen _____ Results: _____ Date last screen: _____

Significant assessment findings:

Recommendations (include referrals):

Follow Up:

Additional information may be attached

Anticipatory Guidance (circle those discussed)

- | | |
|--------------------|----------------|
| 1. Safety/poisons | 8. Lifestyle |
| 2. Nutrition | 9. Development |
| 3. Parenting | 10. Behavior |
| 4. Family planning | 11. Sexuality |
| 5. Discipline | 12. Dental |
| 6. Immunizations | 13. Other |
| 7. Hygiene | |

Comments:

_____ Date

_____ Signature of physician or nurse approved to perform health assessments

HEALTH HISTORY YEAR _____

This information will be held in confidence by the school personnel who handle it. It is important that the questions be answered completely and accurately.

Student's Name _____ D.O.B. _____ Grade ____ Home Phone _____

Parent/Guardian _____ Address _____ Zip _____

HEALTH CONCERNS

Please check any health concerns listed below that your student might have.

- | | | |
|--|---|--|
| <input type="checkbox"/> Vision | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Nosebleeds |
| <input type="checkbox"/> Hearing | <input type="checkbox"/> Headaches | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Speech | <input type="checkbox"/> Seizure Activity | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Dental | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Heart | <input type="checkbox"/> Urinary Problems | <input type="checkbox"/> Allergies(Food, Insects, Environmental) |
| <input type="checkbox"/> Spine Problems | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Frequent Ear Infections | <input type="checkbox"/> Degenerative Disease | <input type="checkbox"/> Attention Deficit Syndrome |
| | (Arthritis, MS, MD, etc.) | <input type="checkbox"/> Other _____ |

Does the above health concern require special attention at school? NO YES-EXPLAIN _____

FOR THE SAFETY AND WELL-BEING OF YOUR CHILD, THIS MEDICAL INFORMATION WILL BE RELEASED TO ALL SCHOOL PERSONNEL WORKING DIRECTLY WITH YOUR CHILD.

MEDICATION.

Is the student on any medication? NO YES If yes, what medicine, amount, time, and why taken? _____

DOCTOR VISITS

Has the student seen a doctor during the last year for:

- | | | | |
|---------------|--|------------|--------------|
| Physical Exam | <input type="checkbox"/> NO <input type="checkbox"/> YES | Date _____ | Doctor _____ |
| Dental Exam | <input type="checkbox"/> NO <input type="checkbox"/> YES | Date _____ | Doctor _____ |
| Vision Exam | <input type="checkbox"/> NO <input type="checkbox"/> YES | Date _____ | Doctor _____ |

IMMUNIZATIONS

Give the most recent types and dates of immunizations.

Tetanus/Diphtheria _____ Date _____ MMR _____ Date _____ Other _____ Date _____

EMERGENCY INFORMATION

Father's Work Place: _____ Phone Number: _____

Mother's Work Place: _____ Phone Number: _____

Emergency Names: (List preferences in order, including parent)

- | | | | |
|---------------|--------------------|---------------|--------------------|
| 1. Name _____ | Phone Number _____ | 3. Name _____ | Phone Number _____ |
| 2. Name _____ | Phone Number _____ | 4. Name _____ | Phone Number _____ |

When a student receives an injury/illness which requires restrictions prescribed by their doctor, they must have a written release from their doctor to participate again in school activities, including competition and practice. In case of an emergency in which a parent or guardian cannot be reached, the principal or acting school official has my permission to use their best judgement for the safety, well-being, and medical attention of my student.

(Parent or Guardian)