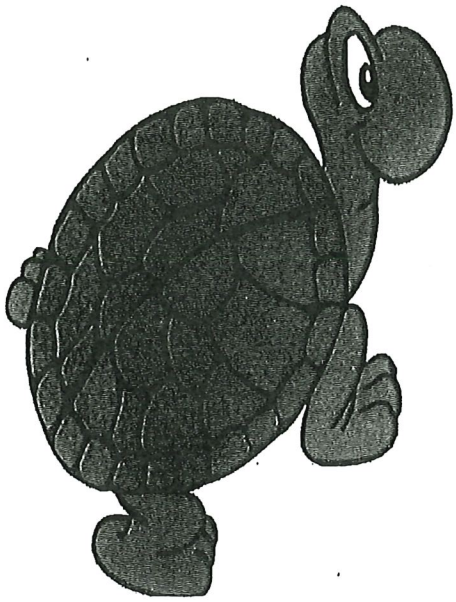

Don't wait!! Vaccinate!!

If your child has turned 4 years old, they may receive their required school vaccinations (DTaP, IPV, MMR and Varicella) **now** and be ready to begin pre-school!

Talk with your healthcare provider to get those vaccinations **now.**

Sponsored by Montgomery County Public Health

Physical Exam and Assessment
Preschool/ Kindergarten
By Physician, Nurse Practitioner or Physician Assistant

Red Oak Community Schools
Inman Primary School
2011 N. 8th Street
Red Oak, IA 51566
Phone: 712-623-6635 Fax: 712-623-6638

Student _____
Female_____ Male_____ Date of Birth_____

Medical and Health History

History	Date	Comments
Allergies: (All Food Allergies will require a Dietary Modification Form)		To Medication:_____ To Foods:_____ To Latex:_____ **Epi-pen**: Yes_____ No_____ **Please include allergy Plan**
Asthma: Please include Asthma Plan from Doctor		
Medications:		
Illness, serious		
Hospitalization/Surgery		
Immunizations Attach IRIS Form	☐ Up to date for school entry ☐ Boosters needed:	
Other:		

Height_____ Weight_____ Blood pressure_____

Vision: Both 20/_____ Right 20/_____ Left 20/_____

System	WNL	Comments:
Skin		
Eyes		
Ears/Hearing		
Mouth		
Speech		
Neck		
Heart		
Lungs		
Abdomen		
Genitourinary		
Musculoskeletal		
Neurologic		
Emotional/social		
Lead screening (required)		Date: _____ Results:
Dental screening (required)		State Dental Form Required
Labs if indicated		

Health conditions requiring intervention/modification at school:

Physical Education Program: Full_____ Limited_____ None_____
Reason:

Examined by (print) _____ Clinic name: _____ Phone: _____

Signature _____ Date: _____ Parent/Guardian_____
Physician

IOWA HHS

Consent and Release of Information

MATURA Action Corporation – PNP or PP (if only OH)

Child's Name:	Age:	Date of Birth:
Address:		Cell Phone: Other Phone:

Gender: ☐ Male ☐ Female ☐ Other	What is your child's race? (select all that apply) ☐ White ☐ Asian or Pacific Islander ☐ Black/African American ☐ Other ☐ Native American	Ethnicity: ☐ Not Hispanic/Latino/a/x ☐ Hispanic/Latino/a/x

Child's Physician:	Child's Dentist:	Medicaid/Hawki ID Number:

☐ **YES**, I give permission for my child to receive a dental screening and fluoride varnish application.

☐ **NO**, I do not give permission for my child to receive a dental screening and fluoride varnish application.

Please answer the following questions:

1. How do you pay for your child's dental care? (please check one)
   ☐ Self pay ☐ Medicaid/Dental Wellness Plan Kids ☐ Hawki ☐ Private dental insurance ☐ Other
2. My child's most recent dental visit was within the past: (please check one)
   ☐ 6 months ☐ 1 year ☐ 3 years ☐ 5 years ☐ has never seen a dentist ☐ Unknown
3. List any concerns you have about your child's mouth or teeth: _____
4. Does your child have a source of medical care? ☐ Yes ☐ No ☐ Unknown
5. Does your child have medical insurance? ☐ Yes ☐ No ☐ Unknown
6. My child's most recent medical visit for a well-child/adolescent exam was within the past:
   ☐ 3 months ☐ 6 months ☐ 12 months ☐ more than 1 year ☐ Unknown
7. Are your child's immunizations up to date? ☐ Yes ☐ No Explain: _____
8. Is your child currently taking any medications? ☐ Yes ☐ No Explain: _____
9. Does your child have any allergies? ☐ Yes ☐ No Explain: _____

I consent to MATURA's use of email and texting to send me scheduling, care coordination and child health services information.
☐ Yes ☐ No Parent/Guardian Email address: _____

- I was offered a Notice of Privacy Practices.
- I understand that this consent for services is valid for one (1) year unless withdrawn in writing by parent, guardian or client (if of legal age).
- I understand that the services that will be received do not take the place of regular dental checkups at a dental office.
- I understand that these services are provided under the Iowa Department of Health and Human Services, Maternal and Child & Adolescent Health Program.
- I understand records created and maintained as part of this program are the property of the Iowa Department of Health and Human Services.
- I understand that the information from these records may be shared with the Iowa Department of Health and Human Services and its agents; Title V contractors and their subcontractors; Iowa Medicaid Enterprise or designee for care coordination, audit and quality improvement, or other legally authorized purposes.

Parent/Guardian Signature Date

I voluntarily authorize MATURA Action Corporation to release, obtain, or exchange information manually and/or via an electronic platform maintained by the Iowa HHS data system with the following: physicians, dentists, schools, preschools & Head Start. This release does not authorize disclosure of material protected by federal and/or state law applicable to substance abuse, mental health and/or AIDS-related information.

Parent/Guardian Signature Date

University of Iowa
Stead Family
Children's Hospital

Iowa KidSight
Consent Form

Date of Screening:_____

Has this child seen an eye doctor within the last year? ☐ No ☐ Yes

If yes, the screening is not necessary. Continue appointments with your eye doctor.

Free vision screening will be offered to children by a local Lions Club. Screenings are in conjunction with Iowa KidSight, in the Department of Ophthalmology and Visual Sciences at the University of Iowa Stead Family Children's Hospital. Vision screening produces images of a child's eyes to determine the presence of eye disorders including far- and near-sightedness, astigmatism, anisometropia (unequal refractive power), strabismus (misaligned eyes), and media opacities (e.g., cataracts). No physical contact is made with a child and no eye drops are used during the vision screening. This screening is approximately 85-90% effective in detecting problems that can cause reduced vision.

Participation is voluntary. This screening is designed for children 6 months of age through Kindergarten. Children who are younger than 6-months old will not be screened. No child will be screened without a signed and completed consent form. Each individual child needs his/her own consent form. If you have questions, please contact: Iowa KidSight, 2431 Coral Court #5, Coralville, Iowa 52241, or 319-353-7616, or kidsight@uiowa.edu.

Please print or type the information below:

Child's Name _____ (_____)
First Middle Last Initials

Male _____ **Female** _____ **Child's Date of Birth** _____/_____/_____ **Child's Age** _____
(MM/DD/YY)

Parent's Name _____

Address _____ **City** _____ **Zip** _____

Home Phone (_____)_____ **Work Phone** (_____)_____

Cell Phone (_____)_____ **E-mail address** _____

I, the undersigned, hereby give permission for my child, _____, to participate in the screening event. I understand the following regarding this program:

1. The information obtained from this screening is preliminary only and does not constitute a diagnosis of vision problems.
2. I will be contacted with the results of the screening through Iowa KidSight at the University of Iowa Stead Family Children's Hospital, or through my child care provider who aided in arranging the screening. I may be contacted regarding follow-up for vision referral by Iowa KidSight staff.
3. This screening result may satisfy the requirement for vision screening upon entry to kindergarten, and may be recorded in the Iowa Immunization Registry.
4. I am responsible for arranging a full eye examination with a doctor of my choosing if my child has been referred as a result of the vision screening. Iowa KidSight recommends a dilated eye examination.
5. The results of your child's eye examination will be shared with Iowa KidSight as a means to help evaluate the screening program's effectiveness.
6. Iowa KidSight will maintain the confidentiality of all records and results.
7. I will not hold the Lions Club and its volunteers, Lions Clubs organizations, University of Iowa Stead Family Children's Hospital, or affiliates, accountable for any errors of commission, omission or other misdiagnosis. There are no foreseeable risks to participating in the Iowa KidSight vision screening.

_____ _____
Signature of Parent or Guardian Date

STUDENT VISION CARD

Student First/Last Name _____ Exam Date _____

Student Date of Birth _____/_____/_____ Student Home Zip Code _____

TO THE PARENT OR GUARDIAN: To fully assess the health of your child's visual system and prevent future learning problems associated with undetected vision problems, regular professional eye exams are essential. Experts estimate that 80% of learning is obtained through vision. Good vision directly contributes to a child's ability to learn while in school. As a part of your back-to-school preparations, it is recommended that you take your child and this card to your family eye doctor for a complete eye health examination. **This card should be signed by the eye care professional and returned to the school nurse or teacher by your child.**

Visual Acuity	**At Distance**		**At Near**	
☐ Without correction	R20/	L20/	R20/	L20/
☐ With present correction	R20/	L20/	R20/	L20/
☐ With new correction	R20/	L20/	R20/	L20/

External Eye Health
☐ Normal ☐ Other

Internal Eye Health
☐ Normal ☐ Other

Vision Analysis

R	L			
☐	☐	Normal eyesight	☐	Eye teaming difficulty
☐	☐	Nearsighted (myopia)	☐	Crossed-eyes (strabismus)
☐	☐	Farsighted (hyperopia)	☐	Eye focusing difficulty
☐	☐	Astigmatism	☐	Sensitivity to light
☐	☐	Amblyopia		

☐ Other _____

Vision Correction Recommendations
☐ No correction necessary
☐ No change in present prescription
☐ New prescription needed

To be worn for:
☐ Constant wear
☐ Distance vision only
☐ Near vision only
☐ As needed

TO THE EYE CARE PROFESSIONAL: Please sign and date this card after examination.

Dr. Name: (Please Print) _____

Date_____ Signature_____

The following organizations recommend the use of the Student Vision Card

IOWA DEPARTMENT OF EDUCATION

IDPH Iowa Department of Public Health

IOWA OPTOMETRIC ASSOCIATION

Iowa PTA everychild. onevoice.

Prevent Blindness Iowa

To order more cards call 1-800-444-1772 • www.iowaoptometry.org

11/13

Medication in School

Red Oak Community School District
Red Oak, Iowa

GENERAL MEDICATION GUIDLINES:

1. Prescription medication is ordered by a licensed medical or osteopathic physician or dentist.
2. When a child is to receive medications during school hours, the following conditions shall apply:
   a. No medication shall be kept on the person or with their belongings
   b. No student shall self-administer at school, except under specific conditions and with prior approval by the school nurse.
   c. All medications shall be left in the charge of the nurse or designated school official to be given to a child at the prescribed times.
   d. Medications are furnished by the parent/guardian.
3. Parents may come to school and administer medication to their own children.

REQUIREMENTS FOR ADMINISTRATION IN SCHOOL:

PRESCRIPTION MEDICATION

1. Medication must be in the original container, prepared and labeled by the pharmacist and clearly showing the name of the child, name and dosage of the medication, and administration schedule along with the name of the physician.
2. The label on the pharmacy bottle will serve in lieu of the doctor's written prescription in most cases.
3. Depending upon the type of medication, the school nurse may request that written instructions over the prescribing doctor's signature be on file at the school.
4. Written permission from parent/guardian must be on file at the school.
5. The school nurse may contact the child's doctor if there is any question regarding dosage/administration.

NON-PRESCRIPTION MEDICATION

1. The medication shall be provided by the parent/guardian in the original container labeled by the manufacturer.
2. Written permission form parent/guardian with name of medication, dosage and times of administration shall be on file.
3. The medication will be dispensed according to the instructions and recommendations on the manufacturer's container.
4. The school nurse may determine that such medication should not be administered to the child. In such cases, the nurse shall attempt to contact parent/guardian. The nurse shall notify the parent/guardian in writing that the medication was not given and reasons therefore.