Saint Elizabeth Ann Seton Catholic School
10650 Aboite Center Road
Fort Wayne, Indiana 46804
Phone (260)432-4001
Fax (260)432-6899

Required Health Forms
For New Families

Contents:

General Health Information

- ☐ CHIRP Consent Form
- ☐ Health Questionnaire- To be completed by parents
- ☐ Physician Certificate of Examination Form- To be completed by a physician

If your student has diabetes, asthma, food allergies, or the need for an Epi-Pen or inhaler while at school, additional forms will need completed.

All forms should be returned to the school office no later than the first day of school

**A <u>current</u> copy of immunization records

must be on file for all students**

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General Health Information

Physical Form & Health Questionnaire Form: All students **NEW** to our school are required to have a recent physical signed by their physician. The Health Questionnaire form is to be completed by parents and also **submitted to the school office no later than the first day of school**. Returning students DO NOT need to complete these forms again.

Immunizations: IC 20-34-4-2 requires that ALL students have the required immunizations PRIOR to, and on file with, the school **before the first day of school**. These immunizations need to be given according to the ACIP (Advisory Committee on Immunization Practices) and Indiana Department of Health, this includes proper intervals between each required dose. The only exception to this rule is a signed "Medical Exemption" form filled out by your child's physician (IC 20-34-3-3), or a "Religious Objection" form signed by the parents/legal guardians (IC 20-34-3-2). Please contact the nurse if you need either of these forms. Religious and Medical exemptions must

CHIRP: As required by IC 20-34-4-6, each school must report immunizations to the State Department of Health. This report is currently done online through CHIRP (Children and Hoosier Immunization Registry Program). We will need a consent signed for each child in order to report this information to the state. Once signed, this consent applies to all years your student(s) attend Saint Elizabeth Ann Seton Catholic School. This form needs to be submitted to the school office no later than the first day of school.

When your child is ill: Children with fever, diarrhea, vomiting or other symptoms of illness should stay at home, and, if indicated, be evaluated by the doctor for diagnosis and appropriate treatment. Any temperature of **99.9 degrees** or above means that your child has a fever and **must stay home for at least 24 hours** (free of fever without the use of acetaminophen or ibuprofen). This means that if your child was sent home from school the day before with a fever, they need to wait **at least** 24 hours before they will be admitted back to school.

Medications: We will only administer FDA approved over–the–counter (OTC) and prescription medications prescribed to your child. These medications should be brought to school by an adult in their original package and accompanied by a medication consent form that can be obtained from the school office. Medication brought into school will only be available during school hours. Our school policies are in accordance with IC 20-34-3-18. All medication will be kept in a locked cabinet with the nurse, or trained staff member dispensing according to the package instructions. Students are not to have medication with them at any time. The only exception to this is if your child needs emergency medication (ex. insulin, an inhaler or an epinephrine injection) and the proper paperwork is filled out and on file with the school. Please see the school office should you need such forms. **A reminder that all cough drops are considered OTC medication and need to be kept in the school office for your child's use**. Please read our full medication policy on the "Medication Consent" form.

Does your child have Asthma, Food Allergies, Diabetes, or History of Seizures? If so, please contact the school office as additional health forms must be completed and on file.

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CHIRP Consent Form

(Required form for all students' health files – Please return ASAP)

The Indiana State Department of Health maintains an electronic immunization registry entitled Children and Hoosiers Immunization Registry Program (CHIRP). CHIRP allows all health care providers within the state of Indiana to enter and view immunization data with this method of electronic documentation. CHIRP ensures that the most up-to-date record of immunizations is available to all health care providers. The Indiana Department of Education mandates that all schools within the state of Indiana utilize CHIRP to document annual immunization reports. We are required to submit these immunization reports to maintain our accreditation. Parents/guardians within our school are being notified of this law and your permission is required to submit the immunization status of your child in this format. The Indiana Department of Education's attorney Dana Long, collaborating with the Indiana State Department of Health, has prepared the consent attached to this document.

I, as a parent/legal guardian to the below stated child, give Saint Elizabeth Ann Seton Catholic School, permission to release the following information to the Indiana State Department of Health's Children and Hoosiers Immunization Registry Program (CHIRP):

STUDENTS NAME, IMMUNIZATION DATA, AND OTHER INFORMATION SUCH AS DATE OF BIRTH OR OTHER IDENTIFYING INFORMATION AS APPLICABLE.

_______________________________Grade: _______ Birthdate: ____/____/____
_______________________________Grade: _______ Birthdate: ____/____/____
_______________________________Grade: _______ Birthdate: ____/____/____
_______________________________Grade: _______ Birthdate: ____/____/____
_______________________________Grade: _______ Birthdate: ____/____/____
_______________________________Grade: _______ Birthdate: ____/____/____

I understand that the information in the registry may be used to verify that my child has received proper immunization and to inform me or my child of my child's immunization status or that an immunization is due according to recommended immunization schedules.

I understand that my child's information may be available to the immunization date registry of another state, a healthcare provider or a providers designees, a local health department, an elementary or secondary school, a child care center, the office of Medicaid policy and planning or a contractor of the office of Medicaid policy and planning, a licensed child placing agency, and a college or university. I also understand that other entities may be added to this list through amendment to I.C. 16-38-5-3.

☐ I hereby give consent to the release of such information

☐ I DO NOT give consent to the release of such information

____ ____________________________
Signature Date

____ ____________________________
Printed Name of Parent or Guardian Telephone #

____
Address

Once signed, this form will apply to all years your student is attending Saint Elizabeth Ann Seton Catholic School

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HEALTH QUESTIONNAIRE

(Parent/Guardian to complete)

This is not an annual form. For any updates or changes to your student's information, please contact the school

Student Name:________________________________ Grade:_____ Date of Birth:_________________

Address:____

Phone Number:______________________________Student lives with:__________________________

Father's Name:______________________________ Mother's Name:__________________________

Health History

Disease/Condition (please circle)			**Disease/Condition** (please circle)		
Seasonal allergies	Yes	No	Measles/Mumps/Rubella	Yes	No
*Food allergy	Yes	No	Pneumonia	Yes	No
*Asthma	Yes	No	Heart Murmur	Yes	No
ADD/ADHD	Yes	No	Emotional disorder	Yes	No
Chicken Pox	Yes	No	Bowel or bladder issues	Yes	No
*Diabetes	Yes	No	Mononucleosis	Yes	No
Diphtheria	Yes	No	Hepatitis	Yes	No
Ears/Infections	Yes	No	Tuberculosis	Yes	No
Epilepsy	Yes	No	Whooping Cough	Yes	No
*Seizures	Yes	No	Other	Yes	No
Handicaps/Impairments (Hearing/Physical/Vision)	Yes	No			

* *Additional forms required- see school nurse*

For any 'yes' circled above, please give explanations and dates of diagnoses.

____

____

____

Has your child had an infectious/communicable disease other than those listed above? Yes No

If yes, please explain, giving relevant dates: ____

Has your child ever been prescribed an Epi-Pen or Auvi-Q Injector due to an allergy? Yes No

If yes, please explain, giving relevant dates: ____

Medication allergies: ____

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HEALTH QUESTIONAIRE PAGE 2

Please list any of the following with month/year:

Operations: ____

Severe Illnesses: ____

Severe Injuries (Head injury, fractures, etc.): ____

____

Hospitalizations: ____

____

Is there any other information about your child's health status that you think the school should know which may be relevant to your child's health and safety or the health and safety of others in the school environment?

____

____

____

Please list any conditions that should be considered in planning your child's school day: ____________

____

____

Physician Name: ______________________________ Phone:______________

Dentist Name: ______________________________Phone:______________

Eye Doctor Name: ______________________________Phone:______________

To the best of my knowledge the above information is complete and accurate. I acknowledge that I have a continuing obligation to inform the school of any changes in my child's health status that are relevant to the information requested by this form.

______________________________ ______________

Parent/Guardian signature Date

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Physician Certificate of Examination Form

(To be completed by the child's physician)

This is not an annual form. For any updates or changes to your student's information, please contact the school.

Name____ Date of Birth____/____/____

Medication Allergies ____

Current Medications: (list name, dosage, and time)

1.____________________________Dosage_______________Time__________

2.____________________________Dosage_______________Time__________

3.____________________________Dosage_______________Time__________

Height______________ **Weight**_______________ **B/P**___________

Eyes: ______________

Ears: ______________

Nose: ______________

Throat______________

Chest:______________

Heart: ______________

Hernia:______________

Extremities: __________

Posture/Scoliosis: ________

Lead level (if indicated) __________

Sickle Cell(if indicated) __________

Hemoglobin (if indicated) ________

Hematocrit (if indicated) _________

Urinalysis (if indicated) __________

Tuberculin test: (if indicated)

Results: _________ Date: __________

Check only if applies:
(If checked additional forms with MD signatures required)

- ☐ Asthma
- ☐ Food Allergies
- ☐ Need for Epi-Pen
- ☐ Heart Condition
- ☐ Diabetes

List Abnormal Results: ____

Is this student physically fit to participate in all physical education programs?

Yes__________ No__________ If no, please explain_____________________________

____

Please list any condition that should be considered in planning this child's school day:

____

Physicians Printed Name: ______________________________

Signature: ____

Date of Exam: ______________________________________