



Required Health Forms For New Families

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- Health Questionnaire- To be completed by parents
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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 current copy of immunization records
must be on file for all students****



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.



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 helped prepare the wording of the below consent.

I, as a parent/legal guardian to the below stated child(ren):

- Give consent to Saint Elizabeth Ann Seton Catholic School to release such information
- I DO NOT give consent to Saint Elizabeth Ann Seton Catholic School to release of such 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.

(FOR FILING PURPOSES, PLEASE LIST ALL STUDENTS REGARDLESS OF CONSENT STATUS)

_____	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.

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



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)

Seasonal allergies Yes No

*Food allergy Yes No

*Asthma Yes No

ADD/ADHD Yes No

Chicken Pox Yes No

*Diabetes Yes No

Diphtheria Yes No

Ears/Infections Yes No

Epilepsy Yes No

*Seizures Yes No

Handicaps/Impairments Yes No

(Hearing/Physical/Vision)

Disease/Condition (please circle)

Measles/Mumps/Rubella Yes No

Pneumonia Yes No

Heart Murmur Yes No

Emotional disorder Yes No

Bowel or bladder issues Yes No

Mononucleosis Yes No

Hepatitis Yes No

Tuberculosis Yes No

Whooping Cough Yes No

Other 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: _____



HEALTH QUESTIONNAIRE

Student Name _____

Please list any of the following with month/year:

Operations: _____

Severe Illnesses: _____

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

Hospitalizations: _____

Diagnostic Procedures: _____

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



Physician Certificate of Examination Form

(To be completed by 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: <i>(If checked additional forms with MD signatures required)</i>
<input type="checkbox"/> Asthma
<input type="checkbox"/> Food Allergies
<input type="checkbox"/> Need for Epi-Pen
<input type="checkbox"/> Heart Condition
<input type="checkbox"/> 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: _____



Immunization History

*****PLEASE ATTACH A COPY OF THE CHILD'S FULL IMMUNIZATION RECORD*****

All students must have an immunization record in the school office before the first day of school. This student MAY NOT attend school without a record of having received the required immunizations listed below. The only exception is to have a medical or religious exemption form filed with the school office.

The following immunizations are the minimum requirement by the State of Indiana for:

Kindergarten –4th Grades

DTaP (5) IPV (4) Hepatitis B (3) MMR (2) Varicella (2) Hepatitis A (2)

5th Grade

DTaP (5) IPV (4) Hepatitis B (3) MMR (2) Varicella (2)

6th Grade

Previous listed plus additional Tdap (1) and MCV (1) and Hepatitis A (2)

7th and 8th Grades

Previous listed, but Hepatitis A is NOT required

(These are the minimum doses that are necessary. All minimum ages and intervals for each vaccination as specified in the CDC guidelines must be followed to be considered valid.)

Printed or stamped name of the Physician completing this form

Physician's signature

Date