

HEALTH

HEALTH AND DENTAL EXAMINATIONS ARE IMPORTANT

Please fill out the medical and disease history.

Have your doctor examine your child and record his findings on the **SCHOOL HEALTH EXAMINATION** form. He will record tests and immunizations given your child and bring them up to date.

Have your dentist examine your child's teeth and record his findings.

Both forms **MUST** be completed and turned on or before the first day of school.

INDIANA STATE LAWS

All elementary school children are now required to be immunized against diphtheria, whooping cough, tetanus, measles, rubella, Hepatitis B, poliomyelitis, chicken pox and Hepatitis A.

Children Entering Kindergarten

A child entering school will have received at least:

- a) five (5) doses of diphtheria-tetanus-pertussis or tetanus-diphtheria vaccine.
- b) four (4) doses of polio vaccine.
- c) two (2) doses of MMR vaccine.
- d) three (3) doses of Hepatitis B
- e) two (2) doses of Varicella
- f) two (2) doses of Hepatitis A

The unsupported parental history of either immunization or clinical illness will not be sufficient to meet requirements. There must be documentation of the receipt of vaccine turned in by the first day of school. **If shots are not current, students will be suspended from school.**

The local health department serving the area in which the child resides will provide immunizations if the parent is unable to secure them from a physician. **If you have medical insurance that covers vaccines, the Health Department will no longer provide shots.**

THE REQUIREMENTS FOR ENROLLMENT IN SOUTH CENTRAL KINDERGARTEN CLASS ARE:

- Five years of age on or before August 1.
- Booster shots and immunizations completed.
- School Health Examination record completed. (signed by physician)*
- Dental Examination record completed. (signed by dentist)*
- An ORIGINAL legal birth certificate from Health Department

****Both the SCHOOL HEALTH EXAMINATION AND THE DENTAL EXAMINATION must be turned in on the first day of school, we are happy to accept the forms before the first day of school. The forms can be turned into the Elementary Office anytime.***

Immunization Information

The LaPorte County Health Department conducts immunization clinics for DIPHTHERIA, TETANUS (Lockjaw), PERTUSSIS (Whooping Cough), POLIO, RUBELLA (German Measles), RUBEOLA (Measles), MUMPS, VARICELLA (Chicken Pox), HEPATITIS B and HEPATITIS A. The cost is \$3.00 per family.

· Every Monday in LaPorte, the 4th floor of the County Complex, in LaPorte by appointment.

· Every Tuesday in Michigan City, 302 West 8th Street, Michigan City 9:00 a.m. to 11:00 a.m. and 1:00 p.m. to 4:00 p.m by appointment.

Criteria for immunization of your child

- ★ Immunization cannot be given to children with colds, fever, rash, allergy to feather, eggs, the drug Neomycin or being treated for cancer leukemia or tuberculosis.
- ★ The child should be accompanied by the parent or guardian.
- ★ Consent forms **MUST** be sign by the child's parent or guardian. Previously sign forms are no longer valid. The new Indiana State Board of Health form is required. If anyone other that a parent bring the child to the Clinic, the parent must have signed a consent form.
- ★ A Record of previous shots are to accompany the child.
- ★ Immunizations are offered to any individual over two months of age.
- ★ The Health department no longer gives free Hepatitis B shots to children over 12 years of age.
- ★ **If you have medical insurance that covers vaccines, the Health Department will no longer provide the shots to you.**

**SOUTH CENTRAL COMMUNITY SCHOOL
STUDENT HEALTH RECORD AND EXAMINATION***

Please fill out completely.

STUDENT NAME _____ SEX _____ DATE OF BIRTH _____

PARENTS _____ ADDRESS _____

PHONE (home) _____ (work) _____

DOCTOR _____ ADDRESS _____ PHONE _____

STATEMENT OF IMMUNIZATION HISTORY

(Please use month, day and year)

DTap/Tdap	1 _____,	2 _____,	3 _____,	4 _____,	5 _____
Poliomyelitis	1 _____,	2 _____,	3 _____,	4 _____	
MMR	1 _____,	2 _____			
Hepatis B vaccine	1 _____,	2 _____,	3 _____		
Hepatis A vaccine	1 _____,	2 _____			
Varicella	1 _____,	2 _____			

PHYSICAL EXAMINATION

Height _____ Weight _____ Urinalysis _____

Please record any abnormal physical or developmental findings _____

List any surgeries or significant factors in child's history _____

List any allergies _____

The child has been adequately immunized _____
This child required further immunizations which will be completed in 3 months _____ 6 months _____.
This will be done by the doctor _____ Health Department _____

Doctor's Signature : _____ **Date** _____

***Due the FIRST day of school**

**SOUTH CENTRAL COMMUNITY SCHOOL
PRE-SCHOOL DENTAL EXAMINATION***

Dentist's Examination
Code: No Defect ---O
Defect-----note condition

_____ Date

NAME _____ SCHOOL _____

Birthdate _____ Sex
Male Female

I. Teeth _____ No. Of Cavities _____

Restoration done _____ Malocclusion _____

II. Soft Tissue _____

III. Recommendation or Remarks:

_____ **D.D.S.**

_____ Date of Examination

*this paper is the **FIRST** day of school
(rev. 02/13)