Dear Parent/Guardian,

The School Wellness Ministry Program provides school health for the Catholic schools. The enclosed packet of information will need to be completed by the first day of school. The law in the State of Indiana requires that your child have certain immunizations in order to attend school. **Please make sure that the immunization information is read carefully, as the Indiana State Department of Health and the Indiana Department of Education have made some mandatory changes for the 2016-2017 school year.** Below is the minimum number of immunizations ***required*** according to grade:

- **Pre-School - Pre-Kindergarten: 4 DTaP, 3 Polio, 3 Hepatitis B, 1 MMR, and 1 Varicella** ***or physician written documentation of history of the Chicken Pox Disease including month and year***

- **Kindergarten – Second Grade: 5 DTaP, 4 Polio, 3 Hepatitis B, 2 MMR, 2 Varicella** ***or physician written documentation of history of the Chicken Pox Disease including the month and year*** **AND NEW, 2 Hepatitis A**

- **Grades Third –Fifth: 5 DTaP, 4 Polio, 3 Hepatitis B, 2 MMR, 2 Varicella** ***or Physician written documentation of history of the Chicken Pox disease including the month and year***

- **Grades Sixth – Eleventh: 5 DTaP, 4 Polio, 3 Hepatitis B, 2 MMR, 1Meningitis, 1Pertussis, and 2 Varicella (*or physician written documentation of the Chicken Pox Disease including month and year for sixth and seventh graders;* a history of the Chicken Pox disease with a written statement from the parent/guardian including the month and year for grades 8 – 11).**

- **Twelfth Grade: 5 DTaP, 4 Polio; 3 Hepatitis B, 2 MMR, 1 Tdap, 2 Varicella or a history of the Chicken Pox Disease with a written statement from parent/guardian including the month and year AND NEW, 2 Meningitis.**

(OVER)

The Indiana State Department of Health has also made ***recommendations* for the 2016-2017 school year** that will eventually become a requirement for more grade levels in the upcoming school years to follow. **These recommendations include:**

- **Second Grade: 2 Hepatitis A vaccinations**

PLEASE PROVIDE ALL IMMUNIZATION DATES, UNLESS SPECIFIED, WITH THE MONTH, DAY AND YEAR (i.e.: xx/xx/xxxx). Please also understand that we have to report immunization data to the Indiana State Department of Health electronically through the Children and Hoosiers Immunization Registry Program (CHIRP). Please return the CHRIP consent with all other health forms provided so immunization data can be reported.

Please be mindful that these are minimum immunization requirements, and children need to have booster shots for certain vaccinations. Consult your child's physician or health care provider to ensure your child is fully immunized. The Center for Disease Control does recommend that 2 doses of Hepatitis A are needed for lasting protection. Hepatitis A vaccination may be given to any child 12 months or older to protect against Hepatitis A. Hepatitis A vaccination is recommended for older children with certain medical conditions that place them at high risk. Hepatitis A vaccine is licensed, safe, and effective for all children of all ages. Even if your child is not at high risk, you may decide you want your child protected against Hepatitis A. Talk to your healthcare provider about Hepatitis A vaccine and what factors may place your child at high risk for Hepatitis A.

Once your child is accepted at school, please send in the forms found in this packet. We will accept exams that were done within the last twelve months. Please look over the form before sending it to the school to be sure that the above required immunization dates are on the form.

The State of Indiana recognizes only 2 reasons for non-immunization of children. One is medical. If your child has a medical reason for not being immunized, there is a form that must be filled out. A physician is the only health care provider that is able to sign this form. The second reason is religious. If religion is the reason, the parent must sign a form **annually. These forms are due on the first day of school.**

You can send in the information in this packet during the summer months to the school or to our office. Fax copies will also be accepted.

Sincerely yours,

Maureen VerVaet, RN, BSN

Health Questionnaire

(Parent/Guardian needs to complete)

Please Print!

Student: _____ Date of Birth: ____/____/____

Address: _____

City: _____Zip: _____Phone Number: _____

School: _____Entering Grade: _____

Father's Name: _____ Mother's Name: _____

Student Lives With:_____

Disease/Condition	Yes (List month/year)	No	Disease/Condition	Yes List month/year	No
Asthma			Mumps		
Diabetes			Rheumatic Fever		
Seizures			Rubella		
Chickenpox			Scarlet Fever		
Measles			Other		

Has your child had an infectious/communicable disease other than those listed above? Please explain giving relevant dates:_____

Please list any of the following with the month/year:

Operations: _____

Illnesses (Eye, ear, heart, stomach, kidney): _____

Severe Injures (Head Injury, Fractures, etc.):_____

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 condition that should be considered in planning your child's school day:

_____

Allergies/Reactions: _____

Physician Name: _____ Phone #:_____

Dentist 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 Signature_____ Date_____

Certificate of Dental Examination

Please Print

Student's Name_____

Parent/Guardian Name_____

School_____

This form is to completed by your dentist.

Dental Examination

Code: No Defect = 0 Defect = Note Condition

1. **Teeth**

    1. Cavities_____
    2. Malocclusion

    _____

    3. Soft Tissue

    _____

    4. Oral Hygiene

    _____

2. **Present Status**
    - Does the patient presently have any tooth decay or other dental defects which may reduce his/her efficiency or prevent him/her from receiving the full benefit of his/her school work?
    - If yes, please explain _____
3. **Recommendations:** _____

_____ _____

Print/Stamp Dentist's Name Date

_____

Signature

SWM 2016

Physician Certificate of Examination Form

(To be completed by a physician)

Please Print!

Name:_____ Date of Birth: ____/____/____

Allergies_____

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

1._____Dosage_____Time_____

2._____Dosage_____Time_____

Height:_____ Weight:_____ B/P:_____

Eyes: _____

Ears: _____ **Lead Level** (if indicated):_____

Nose: _____

Throat: _____ **Sickle Cell** (If indicated):_____

Chest: _____

Heart: _____ **P.P.D.: (Recommended)**

Hernia: _____ Date Given:_____

Extremities: _____ Date Read:_____

Posture/Scoliosis: _____ Results:_____

- 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:_____

Immunization Record: (Month/Day/Year)

DtaP/Tdap:

1._____

2._____

3._____

4._____

5._____

IPV (please indicate if OPV)

1._____

2._____

3._____

4._____

Hepatitis B:

1._____

2._____

3._____

M.M.R:

1._____

2._____

Varicella:

1._____

2._____

Date of Chicken Pox Disease:_____

Hepatitis A:

1._____

2._____

Pertussis:

1._____

Menactra:

1._____

HPV:

1._____

2._____

3._____

Physician Completing this form: _____

Please Print/Stamp

Physician's Signature:_____Date_____