Dear Parents:

The state requires that each child entering kindergarten have a modified eye exam, dental exam, physical exam and current immunizations prior to the start of school.

Forms for the kindergarten health exams are attached. When scheduling an appointment with your dentist, eye doctor, or physician, please **explain that the appointment is for a kindergarten exam and must be done by the first day of school**.

The State Board of Health requires that an immunization record be supplied to the school when a student enters for the first time. This means that your child's immunizations must be **complete when school opens in the fall and a copy of the immunization record be turned in to your child's school on or before the first day of school in August.**

The Hepatitis B series takes 4 to 6 months to complete so it is imperative that immunizations get started now. Contact your doctor or, if you are an Adams County resident, contact the Adams County Health Department at 724-5327. If you are a Medicaid recipient call the Primary Care Clinic at 724-2145 ext. 4502. They will tell you where you can get the immunizations.

## SCHOOL MEDICAL EXAMINATION

This form to be completed by your physician and returned to the building your child will attend kindergarten to the attention of the school nurse.

Name:_____ School:_____

Address:_____

Date:_____

Physician's Examination ___N___-Normal ___AB___-Abnormal

Height_____ Weight_____

B/P_____ Temp_____

Heent_____ Ears: Rt_____ Lt_____

Heart_____ Respiratory_____

Abdomen_____ Neuromuscular System_____

Genitalia & Hernia_____ Skin & Glands_____

Posture & Spine_____ Nutrition_____

Other_____

General Condition Good_____ Poor_____

Recommendation & Comments_____

_____

_____

Physician's Signature_____

PHYSICAL EXAMINATIONS ARE REQUIRED BEFORE ENROLLING YOUR CHILD IN KINDERGARTEN. THIS EXAMINATION IS NO LONGER PROVIDED FREE OF CHARGE AT KINDERGARTEN ROUND UP BY THE PHYSICIANS IN THE DECATUR AREA. PLEASE CONTACT YOUR PHYSICAN TO SCHEDULE YOUR CHILD'S PHYSICAL EXAMINATION.

# Kindergarten Dental Examination

Name:_____ Birth Date:_____
(last) (first) (middle)

Address:_____ School:_____

Please check the appropriate spaces:

Gingva: Inflamed_____ Normal_____ Other:_____

Prophylaxis and Fluoride Treatment: Date of last:_____

Caries, Deciduous Teeth: Yes_____ No_____

Occlusion: Class I_____ Class II_____ Class III_____

Home Care: Good_____ Poor_____

Habits detrimental to oral health: Yes_____ No_____

Please specify:_____

Encircle abnormalities noticed in oral cavity: Throat, Tongue, Lips, Palate, Missing Teeth, Abscess, Other (explain)_____

Dentist Signature:_____

**TO PARENTS: THIS FORM IS TO BE COMPLETED BY YOUR DENTIST AND RETURNED TO THE BUILDING YOUR CHILD ATTENDS TO THE ATTENTION OF THE SCHOOL NURSE.**

Please call your dentist for an appointment. Please explain that you are making an appointment for a kindergarten exam. Take care of the scheduling as soon as possible so dentists are not over scheduled in the fall. A schedule of available dates has been established and is attached.

Free dental exams do not include any X-ray or dental work. If the exam indicates that there is a need for such services and such services are performed, parent(s) will be responsible for payment. **IF YOUR CHILD HAS HAD A DENTAL EXAM WITHIN THE LAST YEAR, TAKE THIS FORM TO YOUR DENTIST FOR COMPLETION.**

## Kindergarten Vision Exam Form

Student's Name:_____ Age:_____ Phone:_____

Parent's Name & Address:_____

1. History (description of past vision and eye health problems plus present observations or complaints relative to vision)

_____

2. Visual Acuity (with/without) Glasses R20/_____ L20/_____

| 3. Cover Test | Distance (20 ft) | Near (16") |
|---|---|---|
| Esotropia (any) | _____ | _____ |
| Exotropia (any) | _____ | _____ |
| Esophoria (5 deg. or more) | _____ | _____ |
| Exophoria (5 deg. or more) | _____ | _____ |
| Hyperphoria (2 deg. or more) | _____ | _____ |

4. Refractive Error

| | | | | | |
|---|---|---|---|---|---|
| Hyperopia | R_____ | L_____ | Is it +1.50 DS or more? | R_____ | L_____ |
| Myopia | R_____ | L_____ | Is it -0.50 DS or more? | R_____ | L_____ |
| Astigmatism | R_____ | L_____ | Is it = 1 DC or more? | R_____ | L_____ |
| Anisometropia | | | Is it = 1 DC or more? | _____ | |

5. Organic (Pathology of eye and /adnexa)_____

_____

6. Color Vision Pass_____ Fail_____

7. If corrective lenses are prescribed, they are for?

Constant Wear_____ Near Vision Only_____ Other_____

8. Corrected Visual Acuity (if corrective lenses prescribed)

R_____ L_____

9. Special Comments and Recommendations_____

_____

10. Re-examination Advised In

Six (6) months_____ Twelve (12) months_____ Other_____

DATE:_____ DOCTOR'S SIGNATURE_____

ADDRESS_____

If your child has had a visual exam within the last year, take this form to your doctor for completion. The modified eye exam **must** be done prior to your child entering kindergarten.

R/2015

# KINDERGARTEN IMMUNIZATION CHECKLIST

**Name**_____ **Birth Date**_____ **School**_____

| Immunization Requirements | Has | Need | Date |
|---|---|---|---|
| DTP, DTaP, or DT, Tdap Td #1 | | | |
| DTP, DTaP, or DT, Tdap, Td #2 | | | |
| DTP, DTaP, or DT, Tdap, Td #3 | | | |
| DTP, DTaP, or DT, Tdap, Td #4 | | | |
| DTP, DTaP, or DT, Tdap, Td #5 | | | |
| OPV or IPV #1 | | | |
| OPV or IPV #2 | | | |
| OPV or IPV #3 | | | |
| OPV or IPV #4 | | | |
| MMR #1 | | | |
| MMR #2 | | | |
| Hepatitis B #1 | | | |
| Hepatitis B #2 (1 month after #1) | | | |
| Hepatitis B #3 (6 months after #2) | | | |
| Varicella #1 | | | |
| Varicella #2 | | | |
| Hepatitis A #1 | | | |
| Hepatitis A #2 | | | |
| Chicken Pox Disease:<br>Date:_____<br>Physician's Signature:<br>_____ | | | |

**** 4 doses of DTaP/DTP/DT are acceptable if 4th dose was administered on or after child's 4th birthday. 3 doses of Polio vaccine are acceptable if 3rd dose was administered on or after child's 4th birthday and the three doses are all IPV or all OPV. ***The 3rd or 4th Polio vaccine must be given on or after the child's 4th birthday."***

**Please have your child's immunizations brought up to date and this form completed by your doctor or clinic. PLEASE BRING YOUR CHILD'S SHOT RECORD WHEN YOU GO TO GET SHOTS. Turn this form in to your child's school on or before the first day of school.**

# Transportation Questions?

**All transportation questions should be directed to North Adams Community Schools.**

**Vicky Girard 724-7146 ext. 2181**

**Transportation Information:**

**Student Name/Address:** _____

**Mothers Name/Address:** _____

**Mothers Phone:** _____

**Fathers Name/Address:** _____

**Fathers Phone:** _____

**Emergency Numbers:** _____

**Morning Pick-up — home or childcare/sitter:** _____

**Afternoon Return — home or childcare/sitter:** _____

**Childcare/Babysitter Information:**

**Name:** _____

**Address:** _____

**Phone:** _____