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.

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.**

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.

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:

Date:_____________

Physician's Signature:

____

**** 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.

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.

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: ________________________________