Health Checklist and Information from the School Nurse

☐ Immunization Record State law requires a certificate of immunization at the time of school enrollment. **The immunization card with dates must be at school before your child will be allowed to attend classes.** Bring a completed immunization card, which includes the kindergarten immunizations, to the Administration building or the school of attendance. The school nurse can validate the cards to assure records of immunizations are complete. Kindergarten students need a DTaP, Polio, MMR, and Varicella booster before they start school. Please turn these in

☐ Kindergarten Physical Your child will need to see their doctor for a kindergarten physical as required by the Newton Community School District. You will have a physical form in this packet to provide to their physician to fill out. If you are needing scheduling/financial assistance with physicals, please contact Newton Clinic at 641-792-2112. .

☐ Initial Health Information Form This form helps us get to know your child's health needs better to provide the most appropriate and safe health care at school by our school nurses. This form is to be filled out by the parent regarding their child's growth and health.

☐ Certificate of Vision Screening: Vision screenings are a state requirement for kindergarten entry. Please call and schedule an appointment with your eye doctor and be sure to mention it is for the kindergarten examination. If you are in need of names of local providers, see the list attached to this letter.

☐ Dental Form Dental screenings are also a state requirement for all kindergarten students. If your child has been to the dentist after the age of 4, your dentist may sign the Certificate of Dental Screening.

☐ The Sick Child This handout may help you in deciding when your child is ill and when to keep him/her home from school. Please call the school if your child will be absent. Messages may be left at any time on the school's answering machine as it is on from the time school is out until the next morning. If your child is absent due to illness, please describe the illness so that we may clearly identify the health problems of our school.

☐ Medication Policy If it is necessary for your child to take medication at school, please follow the medication policy of the school. It is included with these handouts. No medication will be administered without parent signature.

☐ Turn in the Vision Card, Dental Screening, Immunization Card, Physical, and Health Form to the District Office.
(EJH Beard Administration Center 1302 1st Ave W) 641-792-5809 Opt 1 Opt 2

Your child's health is important to his/her ability to progress satisfactorily in school and is our main concern. Please call us if we can be of assistance.

Newton School Nurses

Newton Community School District Elementary Physical Form

Student Name _____ Date of Birth _____
Parent or Guardian _____
Family Physician _____

Date of Physician Visit _____
Height _____ Weight _____
Temp _____ Pulse _____ Respiration _____ Blood Pressure _____

Allergies:
Food (please specify) _____
Medication (please specify) _____
Environmental (please specify) _____
Do any of the above allergies require treatment with emergency medication? _____
If so, please specify below:
What symptoms are to be treated? _____
_____
Medication _____ Dose _____
Frequency _____

Current Medications:
Prescription: _____
_____
Over the counter: _____
_____

Diagnoses: _____
_____
_____

Visual Acuity: Right Eye _____ Left Eye _____
Referral made to eye doctor: _____

Dental Condition: No Obvious Problems _____
Requires Dental Care _____
Requires Urgent Dental Care _____
Referral made to Dentist: _____

Has this child been tested for Lead? Yes _____ No _____
Date of Screening _____
Result of Screening _____

***Iowa House File 158 mandates that each child be screened for lead level before entering Kindergarten.**

Please complete and return this form to your child's school or the District Office

Physical Examination

General Appearance _____

Nutrition _____

Skin _____

Eyes _____

Ears _____

Nose/Throat _____

Heart/Lungs _____

Abdomen _____

Extremities _____

Developmental Screening _____

Any other significant health history including surgeries, injuries, etc? _____
_____

Can this child participate in physical education class or recess without limitations? Yes___ No__
If no, please explain: _____
_____

Examining Physician _____ Date _____

District Office

Newton Community School District
EJH Beard Administration Center
1302 First Avenue West
Newton, Iowa 50208

Questions? Please call our Central Registrar
641.792.5809 (Phone) (District Office, Option 2)

844.4948063 (FAX)

Please complete and return this form to your child's school or the District Office

Newton Community Schools
Initial Health Information From Parents

Name of Child_____ Birthdate_____
School Building_____
Parent/Guardian_____

Does your child have any of the following?
ADD/ADHD _____ Migraines_____ Asthma_____ Diabetes_____ Seizures_____ Eczema_____
Known heart condition_____ Any other medical conditions_____

Is your child potty trained? Yes _____ No _____

Does your child have any allergies or sensitivities? (medications, foods, environmental) Yes ____ No____
Please list _____

Surgeries or hospitalizations (include age): _____
_____

Serious Injuries (include age): _____
_____

Current Medications and purpose: _____
_____

Any prescribed medications that will be given during the school day _____
_____

Family Doctor_____ Last visit _____

Medical Specialists _____ Last visit _____

Dentist_____ Last visit _____

Eye Doctor _____ Last visit _____

Does your child wear glasses? Yes _____ No _____
Other eye problems _____

Does your child have a known hearing problem? Yes _____ No_____

Parent/Guardian Signature_____ Date_____

IOWA
Health and
Human Services

Certificate of Vision Screening

Pursuant with Iowa Code Chapter 641.52
Return completed form to child's school.

Student Information (please print)

Student's Last Name:_____ Student's First Name:_____

Student Address: _____ Zip Code:_____

Date of Birth (M/D/YYYY):_____ Parent/Guardian Phone Number:_____

Screening Information Vision testing requirements can be accomplished either through a screening (see below) or with a comprehensive eye exam (see other side). Screening provider must complete this section or parents may attach a copy of vision screening results given to them by a provider.

Date of Vision Screening: _____

Result (Please check): ☐ Pass ☐ Fail

Testing Method (Please check): ☐ Vision Screening ☐ Photo Screening ☐ Other

Visual Acuity (If available): ☐ With Correction ☐ Without Correction

Right Eye: _____ Left Eye: _____

Referral to Eye Health Professional (Please check): ☐ Yes ☐ No

Business Name/Source of Screening (Please print name of provider office; or name of school if provided by the school nurse): _____

Provider Name (please print): _____Phone:_____

Signature/Credentials of Provider: _____Date:_____

A parent or guardian of a child who is to be enrolled in a public or accredited nonpublic elementary school shall ensure the child is screened for vision impairment at least once before enrollment in Kindergarten **and** again before enrollment in the 3rd grade.

To be valid, a minimum of one child vision screening shall be performed no earlier than one year prior to the date of enrollment in Kindergarten and 3rd grade and no later than six months after the date of the child's enrollment in Kindergarten and 3rd grade.

Eye Exam Section

Pursuant with Iowa Code Chapter 280.7A

To the Parent or Guardian: The Iowa Optometric Association strongly recommends that to fully assess the health of your child's visual system and prevent future learning problems associated with undetected vision problems, regular professional eye exams are essential. Experts estimate that 80% of learning is obtained through vision. **If you choose to** take your child to an eye care professional for a comprehensive eye exam, this side of the form should be filled out and signed by the eye care professional and returned to your child's school nurse or teacher.

Visual Acuity	**At Distance**		**At Near**	
☐ Without correction	R20/	L20/	R20/	L20/
☐ With present correction	R20/	L20/	R20/	L20/
☐ With new correction	R20/	L20/	R20/	L20/

External Eye Health

☐ Normal ☐ Other

Internal Eye Health

☐ Normal ☐ Other

Vision Analysis

R	**L**	
☐	☐	Normal Eyesight
☐	☐	Nearsighted (Myopia)
☐	☐	Farsighted (Hyperopia)
☐	☐	Astigmatism
☐	☐	Amblyopia

☐ Eye teaming difficulty

☐ Crossed eyes (Strabismus)

☐ Eye focusing difficulty

☐ Sensitivity to light

☐ Other

Vision Correction Recommendations

☐ No correction necessary

☐ No change in present prescription

☐ New prescription needed

To be worn for:

☐ Constant Wear ☐ Near vision only

☐ Distance vision only ☐ As needed

To the Eye Care Professional: Please sign and date this card after the examination.

Dr. Name (Please Print) _____

Date_____ Signature_____

STATE OF IOWA
DEPARTMENT OF
Health
AND
Human
SERVICES

CERTIFICATE OF DENTAL SCREENING

This certificate is not valid unless all fields are complete.
RETURN COMPLETED FORM TO CHILD'S SCHOOL.

Student Information (please print)

Student Last Name:	Student First Name:	Birth Date (M/D/YY):

Screening Information (health care provider must complete this section)

Date of Dental Screening: _____

Treatment Needs (check **ONE** only based on screening results, prior to treatment services provided):

☐ **No Obvious Problems** – the child's hard and soft tissues appear to be visually health and there is no apparent reason for the child to be seen before the next routine dental checkup.

☐ **Requires Dental Care** – tooth decay[1] or a white spot lesion[2] is suspected in one or more teeth, or gum infection[3] is suspected.

☐ **Requires Urgent Dental Care** – obvious tooth decay[1] is present in one or more teeth, there is evidence of injury or severe infection, or the child is experiencing pain.

[1] Tooth Decay: A visible cavity or hole in a tooth with brown or black coloration, or a retained root.
[2] White spot lesion: A demineralized area of a tooth, usually appearing as a chalky, white spot or white line near the gumline. A white spot lesion is considered an early indicator of tooth decay, especially in primary (baby) teeth.
[3] Gum infection: Gum (gingival) tissue is red, bleeding, or swollen.

Screening Provider (check **ONE** only): (Ninth grade screening must be provided by DDS/DMD or RDH.)

☐ DDS/DMD ☐ RDH ☐ MD/DO ☐ PA ☐ RN/ARNP

Provider Name: (please print) _____ Phone: _____

Provider Business Address: _____

Signature and Credentials of Provider or Recorder*: _____ Date: _____

*Recorder: An authorized provider (DDS/DMD, RDH MD/DO, PA, or RN/ARNP) may transfer information on this form from another health department. The other health document should be attached to this form.

A screening does not replace an exam by a dentist.
Children should have a complete examination by a dentist at least once a year.
RETURN COMPLETED FORM TO CHILD'S SCHOOL.

Iowa Department of Health and Human Services • Bureau of Oral and Health Delivery Systems
1-866-528-4020 • https://idph.iowa.gov/ohds
A designee of the local board of health or Iowa Department of Health and Human Services may review this certificate for survey purposes.

Rev. 8/26/2022

Vision Providers in the Newton, IA Area

Eye Care Center of Newton 100 N 4th Avenue W Newton, IA 50208 (641) 792-7900	Appointment required Will accept insurance-VSP, Avesis Will accept Medicaid- Iowa Total Care, Wellpoint (formerly Amerigroup) Cost if no insurance= $140-175
Newton Eye Clinic 111 1st Avenue E Newton, IA 50208 (641) 792-7375	Appointment required Will accept insurance Will accept Medicaid- Iowa Total Care, Wellpoint (formerly Amerigroup) Cost if no insurance= $75
Walmart Vision Center 300 Iowa Speedway Drive Newton, IA 50208 (641) 791-5332	Appointment required Will accept Blue Cross/Blue Shield Will accept VSP insurance Will NOT accept Medicaid Cost if no insurance= $120

Physicals

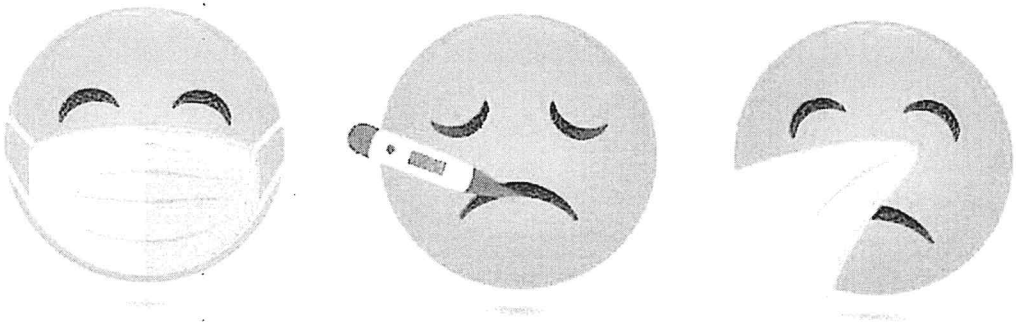
Please contact your primary doctor to schedule an appointment for a physical as soon as possible. Their schedules fill up quickly.

If you do not have insurance, please contact Leeanna Price at Newton Clinic, 641-792-2112. She will arrange for your child to see a doctor there at no cost.

*As of 3/7/2024

I Need to Stay Home If...

- I have a fever of 100.0 degrees or higher
- I have vomited in the last 24 hours
- I have had diarrhea in the last 24 hours
- Unexplained rash



I Am Ready to Return to School...

- When I am fever free for 24 hours without the use of fever reducing medication (Tylenol/Ibuprofen)
- When I am free from vomiting for 24 hours
- When I am free from diarrhea for 24 hours
- My rash has been evaluated by my doctor

Medication Policy

Prescription Medication

1. Must be in a bottle labeled from the pharmacy, with student's name
2. The dosage to be given must be stated
3. The name of the medication to be given must be stated
4. Time of day medication is to be given must be stated
5. Medication must be transported to and from the school by an adult

Non-prescription Medication

1. Must be in a labeled container
2. State for what reason it is to be given
3. State when medication is to be given
4. Cough drops may also be provided by parents, but will be kept in the health office
5. Medication must be transported to and from the school by an adult

All medications given at school must have the written authorization from the parent/guardian. The written medication form will be kept on each student receiving medications.These forms are available at school in the nurse's office.

Note: Any medications that are not picked up by the parent at the end of the school year will be disposed of by the School Resource Officer.