Secondary Students New to Olathe District Schools
Grades 6 – 12

Immunizations	**Before attending class the FIRST TIME in a KANSAS school, PROOF OF IMMUNIZATIONS is required.** • Refer to the attached **Kansas Certificate of Immunization (KCI)** listing immunization requirements by grade and age. • **What immunization records can the school accept?** The KCI completed by a health care provider, a record from your physician office, a copy of the pink immunization card, or an official record from a transferring school.
Physical Examination	**Before SPORT PARTICIPATION** - grade 6 and higher (including drill team and cheerleading) students must do the following: • Receive a physical exam annually using the attached form, the **Pre-Participation Physical Evaluation** (but **not prior to May 1** of the previous school year). *No student will be allowed to try out for a sport (except cheerleading and drill team) without a current sport physical on file with the school nurse.* • Sign all highlighted areas on the form. • Read and sign the highlighted areas for the **Concussion & Head Injury Information Release**
Dental Exam	**We recommend students receive dental exams twice a year.**

Other Health Policies of Interest to Parents:

- Please contact your school nurse regarding any individual student health needs.
- Refer to the district website for a more detailed explanation of our medication policy. **All controlled medications** must be **administered through the health room and require a doctor's note**. We also encourage **emergency medications** to be supervised through the school nurse (**self-administration** require both physician and parent written permission). A small supply of **over-the-counter medications** may be carried by students and self-administered. Students are never to share medications with another student.
- **Emergency care** is provided for all students who are injured or become ill at school, including calling of 911 if necessary.
- Students who are **ill** should remain home until symptom free for 24 hours; and the school nurse should be informed of any **communicable diseases** (Strep throat, chicken pox, etc.) For example, students should be free of fever (100° F or higher) for 24 hours, free of vomiting and/or diarrhea for 24 hours.
- **Health screenings** includes vision testing at grades 6, 8, 9, & 11 and all students new to the district; and hearing testing at grades 8, 11 and all students new to the district. We look forward to serving you.

4/2019

Olathe Public Schools USD 233

Parent Notice of Immunization

Grades 6 -12

Student's Name: ______________________

Immunizations

Kansas regulations (K.S.A. 72-5208 through 72-5211a) require every pupil enrolling for the first time in a Kansas school to present proof that the pupil has received required immunizations. The Kansas Certificate of Immunization lists immunization requirements based on age and grade level.

Proof of **one each of DTaP, IPV, MMR, Hepatitis B, Varicella, and Meningitis (A,C,W,Y)** must be presented prior to admission **and then**, according to our district policy, additional boosters received prior to

- the second Monday in October for students enrolled thru August 31,
- the second Monday of January for students enrolled September 1 thru November 30,
- the second Monday of April for students enrolled December 1 thru March 31.

Parent/Guardian Signature of Notice ______________________

Date ______________________

Student is transferring from ______________________ ______________ ___________
Name of School City State

- -

For school nurse use: Date Student Started School ______________________

Revised 5/2019

Olathe Public Schools USD 233

Permission for Release of Immunization Information to Kansas Immunization Registry

The **Kansas Immunization Registry, KSWebIZ**, is a confidential computer system that collects and selectively discloses information to authorized persons about the vaccination history of persons in the State of Kansas.

The purpose of the Kansas Immunization Registry is to consolidate immunization information among health care professionals, assure adequate immunization levels, and to avoid unnecessary immunizations. Access is limited to individuals and entities that either provide immunization services or are required to ensure that persons are immunized. The privacy of participants and the confidentiality of information contained in the registry are protected at all times by all authorized users.

The Olathe School Nurses are users of the KSWebIZ and with parent permission began entering kindergarten and early childhood student records fall of 2010. Johnson County Health Department has implemented the system, and many area health care providers are in the process of becoming users.

Participation in the program is completely voluntary and no other health or educational records will be shared other than school immunization records. If you would like your student's immunization history to be entered into this system please sign below and return to the school nurse.

Name of Student: _____

I give permission for the school immunization record to be released to the Kansas Immunization Program including the immunization registry for the purpose of assessment, reporting, and prevention of disease. I further understand that this consent will remain effective for a) the length of time my student is enrolled in Olathe District Schools or
b) until it is revoked by a parent/guardian in writing.

Parent/Guardian Signature _____

Date _____

Revised 1/2013

Olathe District Schools
Secondary Health Intake Information

Today's Date: _____ Grade: _____ Information obtained from: _____
Parent/Guardian

Student's Name: _____ Birth Date: _____ Male ___Female ___
Last First MI

Physician: _____Specialist/Other: _____

Preferred Hospital: _____

Current Medication / Treatment	Dose	Time of day	Reason or Diagnosis

Any development, behavioral, feeding, or swallowing concerns? _____

Medical History

Please check yes or no to all, regarding student's medical history.

History	Yes	No	Comments	Medication
Vision correction Vision condition / loss			___Glasses ___Contact Lenses	
Ear Infections			___Currently ___Tubes (x____)	
Hearing loss			Type: Amplification Used: Cochlear Used:	
Headaches				
Seizures			Type of Seizure: Date of onset: Date of last seizure:	
Diabetes			__ Type 1, Insulin-dependent __ Type 2, No insulin needed	
ADD or ADHD				
Mental/behavioral Concerns				
Dental concerns				

History	Yes	No	Comments	Medication
Allergies			Food_____ Seasonal _____ Insect Stings ___ Medication __ Reaction: Anaphylaxis:	
Asthma			List triggers	
Bronchitis/Pneumonia				
Dizziness/Fainting Holds Breath				
Sleep Disturbances				
Nosebleeds			How often?	
Bladder/Kidney Concern				
Urinary Tract Infections				
Stomachache (frequent) Ulcers Irritable bowel			Specify:	
Cardiac/Heart Concerns				
Hospitalizations Surgeries			Age/year/reason	
Accidents Head Injury/Concussion			Type of accident/age/year	

OTC MED AUTHORIZATION

PARENT CONSENT

Name of Student: _____ Date of Birth: _____ Grade/Teacher: _____

List any known allergies or sensitivities that your child has: _____

_____

School personnel must have signed consent (or online enrollment consent) in order to administer these over-the-counter medications. Generic equivalent medications maintained in the health rooms will be used in place of more expensive brand-name items. The school nurse will administer the approved medications as deemed necessary using his/her nursing judgment. Additionally, the school nurse will attempt to contact you upon administration of medication to your son/daughter.

Over-the-counter medications will be administered sparingly when indicated to make your child more comfortable and able to remain at school. For example, the medication may be used for dental pain, mild headaches, orthopedic pain related to recent injury, or in the case of diphenhydramine for symptoms of an acute allergic reaction. You may still need to be contacted for further care of your child. Also, if your child has a fever (100.0 F or higher), district policy requires that your child go home from school and not return until fever-free for 24 hours without aid of medication.

Check all desired medication(s) for your child. Dosage will be according to weight.

- ☐ Acetaminophen (generic for Tylenol®)
- ☐ Ibuprofen (generic for Advil®)
- ☐ Diphenhydramine (generic for Benadryl®)
- ☐ Certirizine (generic for Zyrtec®)
- ☐ Tums® antacid (calcium carbonate)

I understand that the school employee who administers these medications according to proper dosages shall not be held liable for any adverse reactions to the medication administered. I hereby give my permission for my son/daughter to receive the above medication(s) checked on this form as deemed necessary by the school nurse.

Parent Signature	Parent (Printed Name)	Today's Date

Rev. 4/19