# Parent Notice of Immunization Requirements

## Grades 6 -12

**Student's Name:** _____

**Immunizations**

Kansas regulations (K.S.A. 72-6261 through 72-6268) 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/Tdap, IPV, MMR, Hepatitis A, 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

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**For school nurse use:** Date Student Started School_____

**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 KSWebIZ and with parent permission, enter student immunization records into the registry. Johnson County Health Department and many area health care providers also participate in KSWebIZ.

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 _____

*Olathe District Schools*

# Health Intake Information

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

Student's Name: _____ Birth Date: _____ Gender: _____
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?** _____

_____

_____

**If medical history is unknown, check here** ☐

## Medical History

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

| History | Yes | No | Comments | Medication |
|---|---|---|---|---|
| Vision correction<br>Vision condition / loss | | | ___Glasses ___Contact Lenses | |
| Hearing loss | | | Type:<br>Amplification Used:<br><br>Cochlear Used: | |
| Seizures | | | Type of Seizure:<br>Date of onset:<br>Date of last seizure: | |
| ADD or ADHD | | | | |
| Diabetes | | | ☐ Type 1, Insulin dependent<br>☐ Type 2, no Insulin needed | |
| Allergies | | | Food _____ Seasonal _____<br>Insect Stings ___ Medication __<br>Other: _____<br><br>Reaction:<br><br>Anaphylaxis: | |
| Mental/Emotional/ Behavioral Concerns | | | ☐ Anxiety<br>☐ Frequently sad<br>☐ Other: | |

| History | Yes | No | Comments | Medication |
|---|---|---|---|---|
| Asthma | | | List triggers: | |
| Bronchitis/Pneumonia | | | | |
| Cardiac/Heart Concerns | | | | |
| Dental Concerns | | | □ Need a dentist | |
| Dizziness/Fainting<br>Holds Breath | | | | |
| Ear Infections | | | ___Currently ___Tubes (x____) | |
| Headaches | | | Frequency: | |
| Nosebleeds | | | How often? | |
| Sleep Disturbances | | | | |
| Stomachache (frequent)<br>Ulcers<br>Irritable bowel | | | Specify: | |
| Tonsillitis (frequent) | | | | |
| Bladder/Kidney Concern | | | | |
| Urinary Tract Infections | | | | |
| Hospitalizations<br><br>Surgeries | | | Age/year/reason | |
| Accidents<br><br>Head Injury/Concussion | | | Type of accident/age/year | |