PreSchool Students New to Olathe District Schools
Grades PK

Immunizations	**BEFORE ATTENDING CLASS THE FIRST TIME in a Kansas school, PROOF of IMMUNIZATIONS is required** K.S. 72-5208-5212 (amended 1994). • Refer to the attached **Kansas Certificate of Immunization (KCI)** listing immunization requirements by grade and age **Name of vaccine — Number of doses required** **DTaP/DT — 4** **Polio — 3** **MMR — 1** **Hepatitis B — 3** **Hib (Haemophilus influenza) — Up to 4** **PCV (Pneumococcal conjugate) — Up to 4** **Hepatitis A — 2** **Varicella (chicken pox) — 1** **Or history of chicken pox per physician signature** • **What immunization records can the school accept?** The KCI completed by a health care provider, a record from your physician's office, or a copy of the pink immunization card.
Physical Examination	**Upon initial entry into a Kansas School up to age nine, a physical exam is required.** • Schedule the physical as soon as possible. See the reverse side for more information about the school physical. • **Will the school accept my child's recent physical?** Yes, if the physical is less than 12 months old from the day of school entry.
Dental Exam	**We also recommend students receive dental exams twice a year.** • On site services are available at some of our elementary schools. • Contact the school nurse for more information.

Other Health Policies of Interest to Parents:

- Please contact your school nurse regarding any health needs. **All student medications** at the elementary level, **including over-the-counter**, must be **administered through the health room and require a doctor's note**. Limited exceptions apply to this policy (see school nurse).
- **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** (influenza, chicken pox, strep throat, pink eye, head lice, etc.) For example, students should be free of fever (100° F or higher) for 24 hours and free of vomiting and/or diarrhea for 24 hours.
- **Health screenings** include **vision testing** at grades PK, K, 2, 4, and students new to the district; **hearing testing** at grades PK, K, 1, 2, 5 and students new to the district; and height/weight screening annually. We look forward to serving you.

4/2019

Notification Statement of Non-discrimination

The Olathe Public Schools prohibit discrimination on the basis of race, color, ethnicity, national origin, sex, disability, age, religion, sexual orientation or gender identity in its programs, activities or employment, and provides equal access to the Boy Scouts and other designated youth groups to its facilities as required by: Title IX of the Education Amendments of 1972, Title VI and Title VII of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act (ADA), the Individuals with Disabilities Education Act, Section 504 of the Rehabilitation Act of 1973, the Equal Access Act of 1984 and other relevant state and federal laws as amended. Inquiries regarding compliance with applicable civil rights statutes related to race, ethnicity, gender, age discrimination, sexual orientation, gender identity or equal access may be directed to Staff Counsel, 14160 S. Black Bob Road, Olathe, KS 66063-2000, phone 913-780-7000. All inquiries regarding compliance with applicable statutes regarding Section 504 of the Rehabilitation Act and the Individuals with Disabilities Education Act and the Americans with Disabilities Act may be directed to the Assistant Superintendent of Support Services, 14160 S. Black Bob Rd. Olathe, KS 66063-2000, phone 913-780-7000. Interested persons including those with impaired vision or hearing, can also obtain information as to the existence and location of services, activities and facilities that are accessible to and usable by disabled persons by calling the Assistant Superintendent of Support Services. (03/19)

Parent Notice of Immunization and Health Assessment Requirement for Preschool age Students

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, Polio, MMR, Varicella, Hepatitis A, Hepatitis B, PCV (Pneumococcal), and HIB (Haemophilus Influenzae Type B)**, 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.

Health Assessment

Kansas regulations also require that preschool age students enrolling for the first time in a Kansas school present proof of a health assessment performed by a physician or another health professional as specified by K.S.A. 72-5214. Ask the school nurse if you would like a list of agencies that provide health assessments. As an alternative to the health assessment a parent may present a written, signed statement indicating religious opposition to health assessments.

According to our district policy, the health assessment may be conducted

- up to 12 months prior to school entry,
- prior to the second Monday in January, or
- a minimum of 90 calendar days from the student's enrollment in school.

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

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
PK-Elementary 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? ______________________________

____

____

Birth History- PK and Elementary Only

Length of Pregnancy: _weeks **Birth Weight: lb_____oz**

Type of Delivery: (circle) Vaginal Planned C-section Emergency C-Section

Did mother have complications during pregnancy, labor or delivery (high blood pressure, toxemia, bleeding, infection, other)? Please specify: ____

____

Condition of child at birth: ________Normal ______Complications (breathing, heart, NICU stay, other): ____

____

Any of the following (?): cleft lip/palate, heart murmur, genetic abnormality, club feet, other _______no _______yes (please specify): ____

____

Speech / Motor Development - PK and Elementary Only

Developmental task (Check)	Early	On Time	Delayed	Comment/Concern
Sat Alone	______	______	______	___________________
Crawled	______	______	______	___________________
Walked Alone	______	______	______	___________________
First Words/Sentences	______	______	______	___________________
Toilet Trained	______	______	______	___________________

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	
Headaches				
Seizures			Date of last seizure: Type: Date of onset:	
Diabetes			□ Type 1, Insulin-dependent □ Type 2, no insulin needed	
Dizziness/Fainting Holds Breath				
ADD or ADHD				
Ear Infections			□ Currently □ Tubes (x____)	
Hearing Loss			Type: Amplification Used: Cochlear Used:	
Nosebleeds			How often?	
Dental Concerns				
Allergies			Food __________Seasonal __ Insect Stings ___ Medication __ Reaction: Anaphylaxis:	
Asthma			List triggers	
Bronchitis/Pneumonia				
Bladder/Kidney Concerns				
Urinary Tract Infections				
Stomachache (frequent) Ulcers Irritable bowel			Specify:	
Painful bowel movements			How often?	
Sleep Disturbances				
Mental/Emotional/ Behavioral Concerns			□ Anxiety □ Frequently sad Other:	
Cardiac/Heart Concerns				
Hospitalizations /Surgeries			Age/year/reason	
Accidents Head Injury/Concussion			Type of accident/age/year	
Childhood Illnesses				