Consent to Release Information to CHIRP

(Children and Hoosier Immunization Registry Program)

2211 Brooklyn Avenue • Fort Wayne, IN 46802
Phone 260.432.4000 • Fax 260.432.8642

Parent Name: ____________________________

Parent Signature: _________________________

Date: __________________________________

The Indiana State Department of Health is requesting that school districts report immunization rates by sharing individual immunization information. In order to share your child's information we need your consent. Please complete this consent form and return it to your school with other registration materials.

I give St. Joseph Catholic School permission to release the following information concerning my child to the Indiana State Department of Health's CHIRP: *Child's name, date of birth, immunizations, parent/legal guardian's name and other identifying information as applicable.*

I understand that the information in the registry may be used to verify that my child has received proper immunizations and to inform me or my child of my child's immunization status or that an immunization is due according to recommended immunization schedules.

I understand that my child's information will be available to the immunization data registry of another state, a healthcare provider, a local health department, an elementary or secondary school that is attended by the individual, a childcare center, and the office of Medicaid policy and planning or a contractor of the office of Medicaid policy and planning. I also understand that other entities may be added to this list through amendment to I.C. 16-38-5-3. I hereby consent to the release of such information.

:

____________________________________ ________________________________

Child's First, Middle, and Last Name (Print) Parents/Legal Guardian's Signature

Date of Birth: _______________________ Date___________________________

~ Learning to Lead and Serve as Saints ~

Health Questionnaire

(Parent/Guardian needs to complete)

Please Print!

Student: ____________________ Date of Birth: ____/____/____

Address: ________________________________

City: ______________Zip: __________Phone Number: __________

School: ____________________Entering Grade: __________

Father's Name: ______________ Mother's Name: ______________

Student Lives With:________________________________

Disease/Condition	Yes (List month/year)	No	Disease/Condition	Yes List month/year	No
Asthma			Mumps		
Diabetes			Rheumatic Fever		
Seizures			Rubella		
Chickenpox			Scarlet Fever		
Measles			Other		

Has your child had an infectious/communicable disease other than those listed above? Please explain giving relevant dates:________________________________

Please list any of the following with the month/year:

Operations: ________________________________

Illnesses (Eye, ear, heart, stomach, kidney): ________________________

Severe Injures (Head Injury, Fractures, etc.):________________________

Is there any other information about your child's health status that you think the school should know which may be relevant to your child's health and safety or the health and safety of others in the school environment?________________________

Please list any condition that should be considered in planning your child's school day:

____

Allergies/Reactions: ________________________________

Physician Name: ________________________ Phone #:______________

Dentist Name: ________________________ Phone #:______________

To the best of my knowledge the above information is complete and accurate. I acknowledge that I have a continuing obligation to inform the school of any changes in my child's health status that are relevant to the information requested by this form.

Parent Signature________________________ Date______________

Certificate of Dental Examination

Please Print

Student's Name____

Parent/Guardian Name____

School____

This form is to completed by your dentist.

Dental Examination

Code: No Defect = 0 Defect = Note Condition

1. **Teeth**

   1. Cavities____
   2. Malocclusion

      ____
   3. Soft Tissue

      ____
   4. Oral Hygiene

      ____

2. **Present Status**
   - Does the patient presently have any tooth decay or other dental defects which may reduce his/her efficiency or prevent him/her from receiving the full benefit of his/her school work?
   - If yes, please explain _______________________________________

3. **Recommendations:**____

_________________________________ _________________

Print/Stamp Dentist's Name Date

____

Signature

SWM 2016

Physician Certificate of Examination Form

(To be completed by a physician)

Please Print!

Name:____________________ Date of Birth: ____/____/____

Allergies____

Current Medications: (List name, dosage, and time)

1.____________________Dosage______________Time______________

2.____________________Dosage______________Time______________

Height:______________ Weight:______________ B/P:______________

Eyes: ____________________

Ears: ____________________ **Lead Level** (if indicated):__________

Nose: ____________________

Throat: ____________________ **Sickle Cell** (If indicated):__________

Chest: ____________________

Heart: ____________________ **P.P.D.: (Recommended)**

Hernia: ____________________ Date Given:______________

Extremities: ______________ Date Read:______________

Posture/Scoliosis: __________ Results:______________

- Physically fit to participate in all physical education programs? Yes No
  If "No" please explain:______________________________
- Please list any condition that should be considered in planning this child's school day:______________________________

Immunization Record: (Month/Day/Year)

DtaP/Tdap:
1.____________
2.____________
3.____________
4.____________
5.____________

IPV (please indicate if OPV)
1.____________
2.____________
3.____________
4.____________

Hepatitis B:
1.____________
2.____________
3.____________

M.M.R:
1.____________
2.____________

Varicella:
1.____________
2.____________

Date of Chicken Pox Disease:______________

Hepatitis A:
1.____________
2.____________

Pertussis:
1.____________

Menactra:
1.____________

HPV:
1.____________
2.____________
3.____________

Physician Completing this form: ______________________________

Please Print/Stamp

Physician's Signature:______________________________Date______________

FREE Kindergarten Vision Screening

The following Optometrists have volunteered to provide **FREE** Kindergarten screenings in their offices. It is encouraged to take advantage of this rare and FREE preventative health opportunity offered to families in the Allen County Non-Public School Association (ACNPSA.)

It is necessary to follow the guidelines below in order to ensure a free, professional vision screening.

1. Call one of the following offices and identify yourself and the non-public school your child attending.
2. **CALL for an appointment no later than JULY 1** and tell them that your appointment is for pre-kindergarten screening.
3. Be sure to take this kindergarten vison screening report with you for the Optometrist to complete.

Dr. Thomas Baker **260-749-0407**

1318 Minnich Rd. New Haven, IN

Dr. Aileen Heaston **260-489-3996**

10301 Dawson's Creek Blvd. Suite A Fort Wayne, IN

Dr. Troy Hockemeyer **260-493-1505**

10848 Rose Ave. Suite 1 New Haven, IN

Dr. Myra Weber **260-486-8833**

6110 Maplecrest Rd. Fort Wayne, IN

Dr. Thomas Zachman **260-432-1231**

7625 W. Jefferson Blvd. Fort Wayne, IN

****We are most appreciative to the above Optometrists for their services to the Allen County Non-Public Schools. At the time of your child's appointment, PLEASE give the staff a word of thanks for taking time out of their practice to give back to our community.

Kindergarten Vision Examination

Name ______________________________ Birthdate __________
(Last) (First) (MI)

Address ____

Examiner's Report

VISUAL ACUITY

	NEAR	FAR
R eye	________	________
L eye	________	________
Both	________	________

REFRACTION ERROR TEST

Results ____

OCULAR HEALTH TEST

Results ____

BINOCULAR COORDINATION TEST

Results ____

Has the Parent/Guardian been informed of any abnormalities or vision problems needing attention? YES ________ NO ________

Additional remarks or information which you feel might be of assistance to the school in promoting good vision health for this student:

____

Examining Doctor's Signature ________________________ Date ____________

Stamped or Printed Name, Address and Phone Number of Examining Doctor:

____

____

____