Jesup Community School
Missy Walztoni, BSN, RN - Pre-School-12th School Nurse
Phone: 319-827-1700 ext. 1105 or Opt. 6
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Please ensure the following requirements are turned in at the time of enrollment.
Forms are attached here or can be found at www.jesup.k12.ia.us

Requirements for Pre-School:

- Current Physical - must be within 6 months of start of school. State of Iowa Requirement
- Current Immunizations - State of Iowa Requirement
- Health Update Form – this informs me of any health conditions, allergies and gives permission to administer medications if needed
- Dental Exam – only if enrolled in Headstart

Requirements for Pre-K:

- Current Physical- must be within 6 months of start of school. State of Iowa Requirement
- Current Immunizations – State of Iowa Requirement
- Health Update Form
- Dental Exam – only if enrolled in Headstart

Requirements for Kindergarten:

- Current Physical or Health Update Form - Jesup CSD requirement
- Lead Screening- State of Iowa Requirement. Typically done with physical - All children enrolling in Kindergarten are required to have at least one lead test to be in compliance with IAC 641 Chapter 67.
- Dental Exam- State of Iowa Dental Form signed by dentist or dental hygienist. For kindergarten, a screening completed no earlier than age 3, but no later than four months after enrollment is acceptable. All children enrolling in Kindergarten are required to have a dental in compliance with IDPH 641 Chapter 51.
- Vision Exam- State of Iowa Requirement. Each Kindergartner shall have a valid vision screening performed no earlier than 1 year prior to enrollment and no more than 6 months after the date of the child's enrollment in compliance with IAC 641 Chapter 52.
    - Our local Lion's club will provide a FREE screening at the beginning of the school year if consent signed. Consent will be sent home from school.

Thank you!

Missy Walztoni, BSN, RN

Required of all students every year
Parent/Guardian fills out form

JESUP COMMUNITY SCHOOL – ANNUAL STUDENT HEALTH HISTORY UPDATE

Name of Student: _____ Birthdate: _____ Gender: _____ Grade: _____

Is your child currently under treatment for:

- **Asthma:** ☐No ☐Yes: (If yes, please provide a copy of an Asthma Action Plan from your provider to the school yearly. Those who self-carry an inhaler need a consent on file from the provider)
- **Diabetes:** ☐No ☐Type 1 ☐Type 2 (Please provide a copy of Diabetes Medical Management Plan from your provider to the school yearly)
- **Seizures:** ☐No ☐Yes: (Please provide a copy of the Seizure Action Plan from your provider to the school yearly)
- **Allergies:** ☐No ☐Yes: (Any allergy requiring an EPI Pen or high risk for anaphylaxis must have an Allergy Action Plan from your provider yearly)

Allergies	Reaction	Treatment
		☐Avoid ☐Benadryl ☐Epi Pen ☐Other:
		☐Avoid ☐Benadryl ☐Epi Pen ☐Other:

Please check if your child has been diagnosed by a medical provider for any of the following conditions and provide any additional helpful comments:

Condition	**Comment**	**Condition**	**Comment**
☐ADHD/ADD/ Behavior Concerns		☐History of Concussion	
☐Autism/Asperger		☐Frequent Headaches/Migraines	
☐Anxiety ☐Depression		☐ Heart Condition or blood pressure concerns	
☐Bleeding or Clotting Disorder		☐ Skin Condition	
☐Cerebral Palsy		☐Urinary Condition or kidney disease	
☐Cystic Fibrosis		☐Vision: (glasses/contacts)	
☐GI Conditions (Constipation, reflux, IBS, etc.)		☐Hearing Concern ☐ Hearing Aides ☐ Cochlear Implant	
☐Celiac Disease		☐Other:	

List ALL medications taken, whether given at school or at home. Please attach separate sheet if needed.

Medication	Dosage	How Often	Reason	Given
				☐Home ☐ School
				☐Home ☐School
				☐Home ☐School

New Dietary Need/Restriction: ☐No ☐Yes:_____ ***REQUIRES A ONE TIME DIET MODIFICATION FORM signed by provider***

Explain any serious illness, injury, or surgery that your child has had: _____

Has your child had a: Dental visit in the last year? ☐Yes ☐No Dentist's name_____

Physical exam in the last year? ☐Yes ☐No Name of child's physician(s) _____

I give permission to the school health staff to share information relevant to my child's health condition with the appropriate school personnel on an as needed basis to meet my child's health and safety needs. ☐Yes ☐No

I give permission for my child to receive an Epinephrine Injection if he/she is experiencing symptoms of a life-threatening anaphylactic reaction if deemed necessary by a trained individual. ☐Yes ☐No If No, please specify: _____

I give permission to the Jesup Community Schools to give my child a weight appropriate dose of acetaminophen and ibuprofen if deemed necessary by school staff. ☐Yes ☐No ☐Call First PLEASE NOTE: If a student requires over-the-counter medications more than 8 times during the school year, further permission from a healthcare provider will be required before additional doses will be given. Any over-the-counter medication that is taken long term at school must have an MD, DO, PA, or ARNP written approval on file at school. **

If deemed necessary by school staff, I give permission to the Jesup Community Schools to give my child: check all that apply
☐antacids ☐cough drops ☐saline eye drops ☐Vaseline/Lotion ☐Over the counter ointment (hydrocortisone, Benadryl cream or antibiotic oint.)

Signature of Parent/Guardian: _____ Date: _____

Emergency Phone: _____ Hospital Preference: _____
If this number changes during the school year, notify the school office immediately.

Revised 3/22/2023

Example form for Healthcare Provider

Jesup Community Schools
PS, PK and Kindergarten Physical form

Student Name (F,M,L)_____ M☐ F☐ Birth Date_____

Parent/Guardian_____

Family Doctor_____

Medications taken regularly_____

Conditions that would alter school performance_____

PHYSICAL EXAMINATION

Date of Visit_____ **Height**_____ **Weight**_____ **Blood Pressure**_____

General Appearance	
Posture	
Nutrition	
Skin	
Feet	
Nose/Throat	
Eyes/ Ears	
Vision	
Tonsils/ Glands	
Head/ Lungs	
Abdomen	
Genitals	
Other	

Urinalysis	
Blood Count	
Immunizations Given:	

Comments:_____

PHYSICIANS SIGNATURE_____ **Date:**_____

REQUIRED for PS, PK and new students

Provided from your Doctor's office

Iowa Department of Public Health
Certificate of Immunization

Name Last: _____ First: _____ Middle: _____ Date of Birth: _____

Parent/Guardian: _____ Address: _____ Phone: _____

I certify that the above named applicant has a record of age-appropriate immunizations that meet the requirement for licensed child care or school enrollment.

Signature: _____ Date: _____

Physician, Physician Assistant, Nurse, or Certified Medical Assistant

A representative of the local Board of Health or Iowa Department of Public Health may review this certificate for survey purposes.

	Vaccine	Date Given	Doctor / Clinic / Source
Diphtheria, Tetanus, Pertussis DTaP/DTP/DT/ Td/Tdap			
Polio IPV/OPV			
Measles, Mumps, Rubella MMR			
***Haemophilus influenzae* type b** Hib			
Hepatitis B			

	Vaccine	Date Given	Doctor / Clinic / Source
Varicella Chicken Pox *If applicant has a history of natural disease write "Immune to Varicella"*			
Pneumococcal PCV/PPSV			
Meningococcal MCV/MPSV/ Mening B			
Hepatitis A			
Rotavirus			
Human Papilloma Virus HPV			
Other			

January 2013

REQUIRED for Kindergarten

Iowa Department of Public Health
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/YYYY):
Parent or Guardian Name:	Telephone (home or mobile):	
Street Address:	City:	County:
Name of Elementary or High School:	Grade Level:	Gender: ☐ Male ☐ Female

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 healthy 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):
☐ DDS/DMD ☐ RDH ☐ MD/DO ☐ PA ☐ RN/ARNP (High school screen must be provided by DDS/DMD or RDH)

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 onto this form from another health document. 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 Public Health • Oral Health Center
515-242-6383 • 866-528-4020 • www.idph.state.ia.us/ohds/OralHealth.aspx
A designee of the local board of health or Iowa Department of Public Health may review this certificate for survey purposes.