Certificate of Immunization - Please call your provider's office to ensure immunizations are up to date. No entry to 7th grade if any are missing an exemption is not on file.

IOWA Health and Human Services

Certificate of Immunization

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

Parent/Guardian: _____ Address: _____ Phone: (_____)_____

A representative of the local Board of Health or Iowa Department of Health and Human Services may review this certificate for audit purposes.

Vaccine	Vaccine Type	Date Given	Source
Diphtheria, Tetanus, Pertussis DTaP/DTP/ DT/Td/Tdap			
Polio IPV/OPV			
Measles, Rubella MMR			
Haemophilus influenzae type b Hib			

Vaccine	Vaccine Type	Date Given	Source
Hepatitis B Hep B			
Varicella* Chickenpox			
Pneumococcal PCV			
Meningococcal MenACWY			

* If patient has a history of natural disease, write "Immune to Varicella".

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

Name (Print): _____
Physician (MD, DO), Physician Assistant, Nurse, or Certified Medical Assistant

Signature: _____ Date: _____
Physician (MD, DO), Physician Assistant, Nurse, or Certified Medical Assistant

July 2024

Religious Certificate of Immunization Exemption

IOWA Health and Human Services

Religious Certificate of Immunization Exemption

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

A religious exemption may be granted to an applicant only if immunization conflicts with a genuine and sincere religious belief. A Certificate of Immunization Exemption for religious reasons shall be signed by the applicant or, if the applicant is a minor, by the parent or guardian or legally authorized representative. By signing this certificate, you are attesting that the immunization conflicts with a genuine and sincere religious belief and that the belief is in fact religious, and not based merely on philosophical, scientific, moral, personal, or medical opposition to immunizations.

A child granted a religious exemption may be excluded from child care or school during a disease outbreak. The length of time a child is excluded from child care or school will vary depending on the type of disease and the circumstances surrounding the outbreak, and could range from several days to over a month.

By signing this form, I acknowledge the Iowa Department of Health and Human Services has published information regarding immunizations on the Department's website, including:

- Information that failure to complete the required immunizations increases the risk to my child and others of contracting, carrying, and spreading a vaccine-preventable disease; and
- Information that there are children with special health needs attending schools and child care who are unable to be vaccinated or who are at a heightened risk of contracting a vaccine-preventable disease and for whom such a disease could be life-threatening.

The Religious Exemption shall be submitted by the applicant or, if the applicant is a minor, by the applicant's parent or guardian to the admitting official of the school or licensed child care center in which the applicant wishes to enroll.

Name (Print): _____
Applicant, Parent or Guardian

Signature: _____ Date: _____
Applicant, Parent or Guardian

JESUP COMMUNITY SCHOOL – ANNUAL STUDENT HEALTH HISTORY UPDATE

****** SUBMIT HERE ONLINE IF POSSIBLE ******

Name of Student:_____Birthdate: _____ Gender:_____ Grade:_____

1. Does this child have any vision, hearing or speech concerns that the school should be aware of?

   ☐ No ☐ Yes: please explain_____

2. Does this child have a chronic health condition that may require immediate medical attention (i.e. asthma, diabetes, seizures, fainting, allergies such as food, insects, medication)?

   ☐ No ☐ Yes: please explain and include if any emergency medication will be stored at school

   _____

   _____

3. Does your child have any other health conditions that will impact their education or activity for this school year?

   ☐ No ☐ Yes: please explain_____

   _____

4. Does this child have dietary accommodation ordered by your provider? (i.e. Drinking milk - constipation) If yes, this REQUIRES A ONE TIME DIET MODIFICATION FORM signed by provider

   ☐ No ☐ Yes: please

   explain:_____

5. Will this child need to take prescription medication during the school day? If yes, please email Nurse Missy at mwalztoni@jesup.k12.ia.us for further guidance.

   ☐ No ☐ Yes

6. Do you give permission for this child to receive a weight appropriate dose of acetaminophen and ibuprofen if deemed necessary by school staff? ** Nurse will call home before giving it to elementary students. PLEASE NOTE: If a student requires over-the-counter medications more than 8 times during the school year, further written permission from a healthcare provider will be required before additional doses are given.

   ☐ No ☐ Yes

7. Do you give permission for this child to receive over the counter products such as antacids, cough drops, Vaseline, lotion, saline eye drops, ointments such as hydrocortisone, Benadryl cream, or antibiotic ointment? ☐ No ☐ Yes

8. Do you grant permission for your students' health information to be shared with appropriate staff to meet their health and safety needs? ☐ No ☐ Yes:

Signature of Parent/Guardian:_____ Date: _____

Parent/Guardian Emergency Phone:_____Hospital Preference: _____

If this number changes during the school year, notify the school office immediately.