A Letter From The School Nurse

Hello!! My name is Missy Walztoni and I am the Jesup School Nurse for preschool through 12th grade! I graduated from Jesup School in 2003 and went into nursing right away. I have a bachelor's degree in nursing. I live in Jesup with my husband, two children, and our two bulldogs. I take great pride in being able to care for the children in my community!

The State of Iowa requires the following documents on file at school for each student, all of which can be completed by scheduling a well child or physical exam appointment with your primary care physician. The results must be completed on each specific form. Having a physical exam for TK/Kindergarten is not required by the state, but is required by the school district. A health registration form is also required for each grade level yearly and should be completed online!

Preschool	· **Certificate of Immunizations or exemption** · **Physical Exam within last 12 months** · **Dental Screening - only if enrolled in head start** · **Online Health Registration**	**ALL STUDENTS are required to complete the Annual Health Update online!** **Click Below:** ↓ **Online Annual Health Update**
Pre-Kindergarten	· **Certificate of Immunizations or exemption** · **Physical Exam - within last 12 months** · **Dental Screening - only if enrolled in head start** · **Online Health Registration**	
TK and Kindergarten	· **Certificate of Immunizations or exemption** · **Physical Exam - within last 12 months** · **Dental Screening - must be on attached form, any visit after age 3 to present** · **Vision Screening - must be on attached form, valid 1 year prior to enrollment** · **Lead Screening - call your provider to ensure this has been done, no need to submit results** · **Online Health Registration**	

The State of Iowa allows different options to fulfill the vision screening for TK/Kindergarten. You may take the Student Vision Card to your family eye doctor for a comprehensive eye exam, you may have your health care provider fill out the Iowa HHS certificate of vision screening, or you may sign a consent to have your child's vision screened at school by the local Lions club at a later date.

Please reach out to me directly if your child has a medical condition such as asthma, diabetes, seizures, food allergies, or will need to take scheduled medication during the school day. These conditions require specific forms to be submitted. I can be reached by phone at 319-827-1700 ext: 1105 or by email at mwalztoni@jesup.k12.ia.us.

Feel free to check out the school nurse website at: https://jesup.k12.ia.us/elementary-school/nurse for copies of all forms or to see additional resources!

Thank you,
Missy Walztoni, BSN, RN

https://acrobat.adobe.com/id/urn:aaid:sc:VA6C2:cc5eecbd-5322-4153-9eda-b2025ddbadf1

When to Keep Your Child Home from School

1. **Fever greater than 100.4:**
   - May return 24 hours after being fever free without the use of medication.

2. **Any vomiting or diarrhea:**
   - If student has a medical diagnosis that causes vomiting or diarrhea, please send a note from the provider.
   - May return 24 hours after last episode of vomiting and diarrhea.

3. **Sore throat with red, swollen tonsils, white patches on tonsils:**
   - If diagnosed with strep throat, may return 24 hours after starting antibiotics.

4. **Frequent coughing with green nasal drainage, chest discomfort, or difficulty breathing** that prevents the child from participating comfortably in activities or is disruptive to the classroom.

5. **Generalized flu symptoms, low grade fever, achiness, chills, and headache**

6. **Rash or skin lesion with drainage and cannot be contained:**
   - Must provide doctors note stating this is not contagious to return.

7. **Diagnosed as positive for Covid-19, Influenza, RSV:**
   - Must be fever free for 24 hours without medicine, symptoms mild and improving.

If your child needs to stay home due to illness, please contact the school and provide the symptoms or diagnosis your child is experiencing.

Keep in mind returning to school too soon may prolong illness and expose others.

We appreciate your help in keeping our students healthy!

Infant, Toddler, Preschool Age (including Kindergarten entry) Child Health Form HEALTH PROFESSIONAL COMPLETE PAGE

STATE OF IOWA DEPARTMENT OF Health and Human SERVICES

Infant, Toddler, Preschool Age (including Kindergarten entry) Child Health Form

HEALTH PROFESSIONAL COMPLETE PAGE

OR PROVIDE COPY OF WELL CHILD PHYSICAL (ANNUALLY)

Date of Exam: _____

Height/Length: _____ Weight: _____

BMI – starting at age 24 mo.: _____

Head Circumference @ age 2 yr. and under: _____

Blood Pressure-start @ age 3 yr.:_____

Hgb or Hct @ 12 mo.: _____

Lead Risk Assessment: _____

Blood Lead Level @ 1 yr. & 2 yr.: date_____ results_____

Sensory Screening:

Vison Assessment: _____

Vision Acuity: Right eye _____ Left eye _____

Hearing Assessment: Right ear _____ Left ear _____

Tympanometry (may attach results)

Developmental Screening/Surveillance:
(n = normal limits) otherwise describe

Developmental screening results:

Autism screening results:

Psychosocial/behavioral results

Developmental Referral Made Today: ☐ Yes ☐ No

Exam Results: *(n = normal limits) otherwise describe*

HEENT

Oral/Teeth Date of Dental exam _____

Oral Health/Dental Referral Made Today: ☐ Yes ☐ No

Heart

Lungs

Stomach/Abdomen

Genitalia

Extremities, Joints, Muscles, Spine

Skin, Lymph Nodes

Neurological

Allergies

Environmental:
Medication:
Food:
Insects:
Other:

Child Name: _____

Date of Birth: _____ **Age:** _____

Immunization and TB Testing: (check as indicated)

☐ IDPH Certificate of Immunization reviewed and signed

☐ TB testing completed (only for high-risk child)

Health provider authorizes the child may receive the following at child care: (include *over-the-counter medications)*

	Name	Dosage
☐ Diaper cream/ointment:		
☐ Fever or Pain reliever:		
☐ Sunscreen:		
☐ Other		

Prescribed Medication should be listed with written instructions for use in child care. Medication forms available at https://hhs.iowa.gov/hcci/products

Additional Referrals made:

☐ _____

_____

Health Provider Assessment Statement:

☐ The child may participate in developmentally appropriate early care/learning with ***NO*** health-related restrictions.

☐ The child may participate in developmentally appropriate early care/learning ***with restrictions*** (see comments).

☐ The child has a special needs care plan

Type of plan _____

(Please complete and give to parent for child care templates at https://hhs.iowa.gov/hcci/products)

Comments:

May use stamp

Signature _____

Circle Provider Type: MD DO PA ARNP Chiropractor

Address: Telephone:

American Academy of Pediatrics has recommendations for frequency of childhood preventative pediatric health care (Bright Futures July 2022) https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf?_ga=2.153767288.1525543973.1674849857-346854326.1661880588

PARENT/GUARDIAN (COMPLETE THIS PAGE ANNUALLY) **Child's Name:** _____

Tell us about your child's health. Place an **X** in the box ☒ if the sentence applies to your child. Check *all* that apply to your child. This will help your health care provider plan your child's physical exam.

☐ **Growth** - I am concerned about my child's growth.

☐ **Appetite** - I am concerned about my child's eating/feeding habits or appetite.

☐ **Rest** - I am concerned about the amount of sleep my child needs.

☐ **Illness/Surgery/Injury** - My child had a serious illness, injury, or surgery.

Please describe:

☐ **Physical Activity** - My child must restrict physical activity.

Please describe:

☐ **Development and Learning** - I am concerned about my child's behavior, development, or learning.

Please describe:

☐ **Allergies** - My child has allergies. (Medicine, food, dust, mold, pollen, insects, animals, etc.).

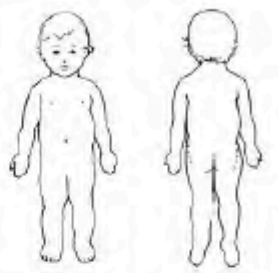
Please describe:

☐ **Special Needs Care Plan** - My child has a special need and needs a care plan for child care. Please discuss with your health care provider.

☐ **Body Health** - My child has skin problems, birthmarks, Mongolian spots, etc.

Map and describe color/shape of skin markings

birthmarks, scars, moles



☐ Eyes \ vision, glasses
☐ Ears \ hearing, hearing aids or device, earaches, tubes in ears
☐ Nose problems, nosebleeds, runny nose
☐ Mouth, teething, gums, tongue, sores in mouth or on lips, mouth-breathing, snoring
☐ Nervous System, headaches, seizures
☐ Breathing problems, asthma, cough, croup
☐ Heart, heart murmur
☐ Stomach aches, upset stomach, spitting-up
☐ Using toilet, toilet training, urinating
☐ Bones, muscles, movement, pain when moving, uses assistive equipment.
☐ Needs special equipment.

List equipment:

☐ **Medication**[1] - My child takes medication.

Medication Name	Time Given	Reason for Medication

☐ **Child has Emergency Medication** - Epipen, Respiratory Inhaler, Nebulizer, etc. (Please complete care/action plan) templates at https://hhs.iowa.gov/hcci/products

Parent/Guardian questions or comments for the health care provider:

Parent/Guardian Signature (required) _____ Date: _____

[1] Please review the child care program's policies about the use of medication at child care.

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

Certificate of Immunization

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

Certificate of Dental Screening

IOWA | Health and Human Services

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 (MM/DD/YY):

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; Ninth-grade screening must be provided by DDS/DMD or RDH.)

☐ DDS/DMD ☐ RDH ☐ MD/DO ☐ PA ☐ RN/ARNP

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 on this form from another health department. 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.

Iowa Department of Health and Human Services • Bureau of Family Health – Oral Health Section

1-866-528-4020 • *https://hhs.iowa.gov/programs/programs-and-services/dental-and-oral-health*

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

Rev. 8/24

[470-0021, Certificate of Vision Screening]

IOWA Health and Human Services

Certificate of Vision Screening

Pursuant with Iowa Code Chapter 641.52
Return completed form to child's school.

Student Information (please print)

Student's Last Name:_____ Student's First Name:_____

Student Address: _____ Zip Code:_____

Date of Birth (M/D/YYYY):_____ Parent/Guardian Phone Number:_____

Screening Information Vision testing requirements can be accomplished either through a screening (see below) or with a comprehensive eye exam (see other side). Screening provider must complete this section or parents may attach a copy of vision screening results given to them by a provider.

Date of Vision Screening: _____

Result (Please check): ☐ Pass ☐ Fail

Testing Method (Please check): ☐ Vision Screening ☐ Photo Screening ☐ Other

Visual Acuity (If available): ☐ With Correction ☐ Without Correction

Right Eye: _____ Left Eye: _____

Referral to Eye Health Professional (Please check): ☐ Yes ☐ No

Business Name/Source of Screening (Please print name of provider office; or name of school if provided by the school nurse): _____

Provider Name (please print): _____Phone:_____

Signature/Credentials of Provider: _____Date:_____

A parent or guardian of a child who is to be enrolled in a public or accredited nonpublic elementary school shall ensure the child is screened for vision impairment at least once before enrollment in Kindergarten **and** again before enrollment in the 3rd grade.

To be valid, a minimum of one child vision screening shall be performed no earlier than one year prior to the date of enrollment in Kindergarten and 3rd grade and no later than six months after the date of the child's enrollment in Kindergarten and 3rd grade.

Eye Exam Section

Pursuant with Iowa Code Chapter 280.7A

To the Parent or Guardian: The Iowa Optometric Association strongly recommends that to fully assess the health of your child's visual system and prevent future learning problems associated with undetected vision problems, regular professional eye exams are essential. Experts estimate that 80% of learning is obtained through vision. **If you choose to** take your child to an eye care professional for a comprehensive eye exam, this side of the form should be filled out and signed by the eye care professional and returned to your child's school nurse or teacher.

Visual Acuity	**At Distance**		**At Near**	
☐ Without correction	R20/	L20/	R20/	L20/
☐ With present correction	R20/	L20/	R20/	L20/
☐ With new correction	R20/	L20/	R20/	L20/

External Eye Health
☐ Normal ☐ Other

Internal Eye Health
☐ Normal ☐ Other

Vision Analysis

R	**L**	
☐	☐	Normal Eyesight
☐	☐	Nearsighted (Myopia)
☐	☐	Farsighted (Hyperopia)
☐	☐	Astigmatism
☐	☐	Amblyopia

☐ Eye teaming difficulty
☐ Crossed eyes (Strabismus)
☐ Eye focusing difficulty
☐ Sensitivity to light
☐ Other

Vision Correction Recommendations
☐ No correction necessary
☐ No change in present prescription
☐ New prescription needed

To be worn for:
☐ Constant Wear ☐ Near vision only
☐ Distance vision only ☐ As needed

To the Eye Care Professional: Please sign and date this card after the examination.

Dr. Name (Please Print) _____

Date_____ Signature_____

STUDENT VISION CARD

STUDENT VISION CARD

Student First/Last Name _____ Exam Date _____

Student Date of Birth ____/____/____ Student Home Zip Code _____

TO THE PARENT OR GUARDIAN: To fully assess the health of your child's visual system and prevent future learning problems associated with undetected vision problems, regular professional eye exams are essential. Experts estimate that 80% of learning is obtained through vision. Good vision directly contributes to a child's ability to learn while in school. As a part of your back-to-school preparations, it is recommended that you take your child and this card to your family eye doctor for a complete eye health examination. **This card should be signed by the eye care professional and returned to the school nurse or teacher by your child.**

Visual Acuity	**At Distance**		**At Near**	
☐ Without correction	R20/	L20/	R20/	L20/
☐ With present correction	R20/	L20/	R20/	L20/
☐ With new correction	R20/	L20/	R20/	L20/

External Eye Health
☐ Normal ☐ Other

Internal Eye Health
☐ Normal ☐ Other

Vision Analysis

R	L			
☐	☐	Normal eyesight	☐	Eye teaming difficulty
☐	☐	Nearsighted (myopia)	☐	Crossed-eyes (strabismus)
☐	☐	Farsighted (hyperopia)	☐	Eye focusing difficulty
☐	☐	Astigmatism	☐	Sensitivity to light
☐	☐	Amblyopia		

☐ Other _____

Vision Correction Recommendations

☐ No correction necessary
☐ No change in present prescription
☐ New prescription needed

To be worn for:
☐ Constant wear
☐ Distance vision only
☐ Near vision only
☐ As needed

TO THE EYE CARE PROFESSIONAL: Please sign and date this card after examination.

Dr. Name: (Please Print) _____

Date_____Signature_____

The following organizations recommend the use of the Student Vision Card

IDPH
IOWA OPTOMETRIC ASSOCIATION
Iowa PTA everychild.onevoice.
Prevent Blindness Iowa

To order more cards call 1-800-444-1772 • www.iowaoptometry.org

11/13

IOWA HEALTH CARE | Stead Family Children's Hospital

Iowa KidSight Consent Form

Date of Screening:_____ #_____

Has this child seen an eye doctor within the last year? ☐ No ☐ Yes

(If yes, please continue appointments with your child's eye doctor.

Free vision screening will be offered to children by a local Lions Club. Screenings are in conjunction with Iowa KidSight, in the Department of Ophthalmology and Visual Sciences at the University of Iowa Stead Family Children's Hospital. Vision screening produces images of a child's eyes to determine the presence of eye disorders: far- and near-sightedness, astigmatism, anisometropia (unequal refractive power), strabismus (misaligned eyes), and media opacities (e.g., cataracts). No physical contact is made with a child and no eye drops are used during the vision screening. This screening is approximately 85-90% effective in detecting problems that can cause reduced vision.

Participation is voluntary. This screening is designed for children 6 months of age through Kindergarten. Children who are younger than 6-months old will not be screened. The images will not be evaluated without a signed and completed consent form. Each individual child needs their own consent form. If you have questions, please contact: Iowa KidSight, 2431 Coral Court #5, Coralville, Iowa 52241, Phone: 319-353-7616 or email: kidsight@uiowa.edu.

Please print or type the information below:

Child's First Name_____**Last Name**_____

Female____**Male**____**Other**____ **Child's Date of Birth** _____/_____/_____ **Child's Age** _____
(MM/DD/YY)

Race/Ethnicity: ☐**American Indian** ☐**Alaska Native** ☐**Asian** ☐**Black or African American**
☐**Hispanic or Latino** ☐**Pacific Islander** ☐**White or Caucasian** ☐**Other**

Parent's Name _____

Address _____ **City** _____ **Zip** _____

Cell Phone (_____**)**_____ **Other Phone (**_____**)**_____

E-mail address_____

I, the undersigned, hereby give permission for my child,_____**, to participate in the screening event. I understand the following regarding this program:**

1. The information obtained from this screening is preliminary only and does not constitute a diagnosis of vision problems.
2. I will be contacted with the results of the screening through Iowa KidSight at the University of Iowa Stead Family Children's Hospital, or through my child's site of screening. I may be contacted regarding follow-up for vision referral by Iowa KidSight staff.
3. This screening result may satisfy the requirement for vision screening upon entry to kindergarten, and may be recorded in the Iowa Immunization Registry.
4. I am responsible for arranging a full eye examination with a doctor of my choosing if my child has been referred as a result of the vision screening. Iowa KidSight recommends a dilated eye examination.
5. The results of your child's eye examination will be shared with Iowa KidSight as a means to help evaluate the screening program's effectiveness.
6. Iowa KidSight will maintain the confidentiality of all records and results.
7. I will not hold the Lions Club and its volunteers, Lions Clubs organizations, University of Iowa Stead Family Children's Hospital, or affiliates, accountable for any errors of commission, omission or other misdiagnosis. There are no foreseeable risks to participating in the Iowa KidSight vision screening.

_____ _____
Signature of Parent or Guardian **Date**

Revised 6-2024

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.