To: Parents / Guardians

From: School Nurse

RE: Kindergarten Health Information

We look forward to your child attending school with us next year. The information below will best help us to meet your child's health needs while at school and ensure that we meet the health requirements for school attendance.

Please inform the school nurse as soon as possible of any chronic health conditions, food allergies or medical procedures your child may require during the school day so that we can be ready on the first day of school to meet your child's needs.

Requirements for School:

1. **Immunizations:** Iowa law requires that every child have a completed immunization record at the school by the first day of classes. Please use the state approved immunization form from your health care provider. The school nurse will review your child's immunization records to assure compliance with the requirements for school attendance.
2. **Blood Lead Screening:** Completed before six years of age.
3. **Dental Screening:** Completed by a dentist, dental hygienist, doctor, nurse or physician assistant between three and six years of age. Please ask your health care provider to use the state approved dental screening form.

Recommendations for School:

1. **Physical Exam** - The Des Moines Public School District encourages children to have periodic physical examinations in kindergarten, 3rd, 6th and 9th grades. Please provide the student medical report from your health care provider.
2. **Vision Screening** - The Iowa Legislature recommends that an eye examination be completed by an optometrist or ophthalmologist. Please return the state approved vision form or the green vision card from your provider to the school nurse following your child's next vision appointment.

When your child is ill:

Please note that when your child becomes ill at school, the school will contact you at the phone numbers you provide. In addition to the names and phone numbers of the parent/guardian, please provide the school with at least two emergency contact names with current and working phone numbers. It is ***very*** important that you notify the school when your emergency contact phone numbers change.

General guidelines of when to keep your child home from school are:

- A temperature of 100.4°F (38.0 degrees C) or above. Please note that the school nurse can exercise discretion and exclude your child from school at a lower temperature if other symptoms of communicable illness are present or when symptoms are persistent and not conducive to school participation or if it is felt that the symptoms may cause a risk of spread of illness to others. **Your child should be free of fever without the use of fever-reducing medicine for 24 hours before returning to school.**

- Undiagnosed rash associated with fever or behavior changes that is suggestive of contagious disease
- Repeated episodes of vomiting or diarrhea
- Headache accompanied by fever or vomiting
- Persistent uncontrolled cough
- Any illness that could disrupt the student's learning process or will result in a greater need for care than the staff can provide without compromising the health and safety of other children

If your child is placed on antibiotics for treatment of an infection, he or she needs to be on the antibiotics for 24 hours before returning to school.

Please ask your health care provider to communicate with the school nurse when your child is diagnosed with a contagious illness. You may turn in medical notes to the school nurse that are from the doctor, dentist, or other health care provider whenever your child is seen for an illness, injury or follow up care. Medical notes are helpful to the school in determining attendance status and in planning for follow up care for your child at school.

School Medication Needs:

All medications given at school must be prescribed by a physician. Written parent/guardian consent is also required for medications to be given at school. Medications must be in the original pharmacy container appropriately labeled with the student's name and details for administration of medication. Over-the-counter medications can only be given at school with signed physician instructions and signed parental permission form. All medications must be provided to the school from the parent/guardian.

Food Related Information:

If your child has a known food allergy, please notify the school nurse so the appropriate care can be given at school. Because many illnesses are transmitted through food, any food shared at school sponsored activities that involve children must be commercially prepared and packaged and served using district serving guidelines. Please check with the school nurse if you have questions about the district's food guidelines.

School Health Screenings:

Because good health can lead to better learning, the school will periodically screen your child for health concerns that could interfere with learning. Some health screenings that may be offered during the school year are dental, vision and hearing. Please let the school nurse know if you do not want your child to participate in these screening programs.

Please feel free to contact the school nurse if you have questions or need help in arranging for health care services.

Thank you,

DMPS School Nurse

Para: Padres / Tutores

De: Enfermera de la escuela

RE: Información de salud de kindergarten

Esperamos que su hijo asista a la escuela con nosotros el próximo año. La siguiente información nos ayudará mejor a satisfacer las necesidades de salud de su hijo mientras está en la escuela y garantizar que cumplamos con los requisitos de salud para la asistencia a la escuela.

Informe a la enfermera de la escuela lo antes posible sobre cualquier condición de salud crónica, alergias alimentarias o procedimientos médicos que su hijo pueda requerir durante el día escolar para que podamos estar listos el primer día de clases para satisfacer las necesidades de su hijo.

Requisitos para la escuela:

1. **Vacunas: La** ley de Iowa requiere que cada niño tenga un registro de vacunación completo en la escuela para el primer día de clases. Utilice el formulario de inmunización aprobado por el estado de su proveedor de atención médica. La enfermera de la escuela revisará los registros de vacunación de su hijo para asegurar el cumplimiento de los requisitos para la asistencia a la escuela.
2. **Prueba de plomo en la sangre:** Se completa antes de los seis años.
3. **Evaluación dental:** Completada por un dentista, higienista dental, médico, enfermera o asistente médico entre tres y seis año. Pídale a su proveedor de atención médica que use el formulario de evaluación dental aprobado por el estado.

Recomendaciones para la escuela:

1. **Examen físico** - El Distrito de Escuelas Públicas de Des Moines alienta a los niños a tener exámenes físicos periódicos en kindergarten, 3º, 6º y 9º grado. Proporcione el informe médico del estudiante de su proveedor de atención médica.
2. **Examen de la vista** - La Legislatura de Iowa recomienda que un optometrista o oftalmólogo complete un examen ocular. Devuelva el formulario de visión aprobado por el estado o la tarjeta de visión verde de su proveedor a la enfermera de la escuela después de la próxima cita de la vista de su hijo.

Cuando su hijo está enfermo:

Tenga en cuenta que cuando su hijo se enferme en la escuela, la escuela se comunicará con usted a los números de teléfono que proporcione. Además de los nombres y números de teléfono del padre/tutor, proporcione a la escuela al menos dos nombres de contacto de emergencia con números de teléfono actuales y de trabajo. Es ***muy*** importante que notifique a la escuela cuando cambien sus números de teléfono de contacto de emergencia.

Las pautas generales de cuándo mantener a su hijo en casa y no ir a la escuela son:

- Una temperatura de 100.4°F (38.0 grados C) o más. Tenga en cuenta que la enfermera de la escuela puede ejercer discreción y excluir a su hijo de la escuela a una temperatura más baja si hay otros síntomas de enfermedad transmisible o cuando los síntomas son persistentes y no conducen a la participación escolar o si se considera que los síntomas pueden causar un riesgo de propagación de la enfermedad a otros. **Los estudiantes que están enfermos deben QUEDARSE EN CASA hasta que estén libres de síntomas de enfermedad durante 24 horas y / o si los resultados de la prueba están pendientes**.

- Erupción cutánea no diagnosticada asociada con fiebre o cambios de comportamiento que sugieren una enfermedad contagiosa
- Episodios repetidos de vómitos o diarrea
- Dolor de cabeza acompañado de fiebre o vómitos
- Tos persistente no controlada
- Cualquier enfermedad que pueda interrumpir el proceso de aprendizaje del estudiante o resulte en una mayor necesidad de atención de la que el personal puede proporcionar sin comprometer la salud y la seguridad de otros niños.

Si a su hijo se le administran antibióticos para el tratamiento de una infección, debe tomar los antibióticos durante 24 horas antes de regresar a la escuela.

Pídale a su proveedor de atención médica que se comunique con la enfermera de la escuela cuando a su hijo le diagnostiquen una enfermedad contagiosa. Puede entregar notas médicas a la enfermera de la escuela que sean del médico, dentista o otro proveedor de atención médica cada vez que su hijo sea visto por una enfermedad, lesión o atención de seguimiento. Las notas médicas son útiles para la escuela en la determinación del estado de asistencia y en la planificación de la atención de seguimiento para su hijo en la escuela.

Necesidades de medicamentos escolares:

Todos los medicamentos administrados en la escuela deben ser recetados por un médico. También se requiere el consentimiento escrito de los padres / tutores para que los medicamentos se administren en la escuela. Los medicamentos deben estar en el envase original de la farmacia debidamente etiquetado con el nombre del estudiante y los detalles para la administración del medicamento. Los medicamentos de venta libre solo se pueden administrar en la escuela con instrucciones firmadas por el médico y un formulario de permiso de los padres firmado. Todos los medicamentos deben ser proporcionados a la escuela por el padre/tutor.

Información relacionada con los alimentos :

Si su hijo tiene una alergia alimentaria conocida, notifique a la enfermera de la escuela para que se pueda brindar la atención adecuada en la escuela. Debido a que muchas enfermedades se transmiten a través de los alimentos, cualquier alimento compartido en actividades patrocinadas por la escuela que involucren a niños debe prepararse comercialmente y empaquetarse y servirse según las pautas de servicio del distrito. Consulte con la enfermera de la escuela si tiene preguntas sobre las pautas alimentarias del distrito .

Exámenes de salud escolar :

Debido a que la buena salud puede conducir a un mejor aprendizaje, la escuela examinará periódicamente a su hijo para detectar problemas de salud que puedan interferir con el aprendizaje. Algunos exámenes de salud que se pueden ofrecer durante el año escolar son dentales, de la vista y de audición. Informe a la enfermera de la escuela si no desea que su hijo participe en estos programas de detección.

No dude en ponerse en contacto con la enfermera de la escuela si tiene preguntas o necesita ayuda para organizar servicios de atención médica .

Gracias,

Enfermera escolar DMPS

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

STATE OF IOWA
DEPARTMENT OF
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 (M/D/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 health 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.
RETURN COMPLETED FORM TO CHILD'S SCHOOL.

Iowa Department of Health and Human Services • Bureau of Oral and Health Delivery Systems
1-866-528-4020 • https://idph.iowa.gov/ohds
A designee of the local board of health or Iowa Department of Health and Human Services may review this certificate for survey purposes.

Rev. 8/26/2022

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_____

Diet Modification Request Form

Modifications are required by The United States Department of Agriculture (USDA) to accommodate a disability. Under Section 504, the ADA, and Departmental Regulations of 7 CFR part 15b define a person with disability as any person who has a physical or mental impairment which substantially limits one or more major life activities, has a record of such impairment, or is regarded as having such an impairment**. "Major life activities" are broadly defined and include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working. "Major life activities" also include operation of a major bodily function, including but not limited to, functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.**

This form must be completed by a "medical authority" that is authorized by state law to write medical prescriptions: In Iowa this includes only Medical Doctors (MD), Doctors of Osteopathic Medicine (DO), Physician's Assistants (PA), Advanced Registered Nurse Practitioners (ARNP) or Dentists.

Return the completed form to your organization or provider: _____
(Head Start, Summer Meal Provider, Day Care, Home Provider, or School)

Participant's Name: _____ Birth Date: _____ Grade:_____

Parent/Guardian: _____
(*Name)* *(Phone or email)*

1) Describe the medical need related to the diet order and "major life activity" **(see above)** affected.
Example: Allergy to peanuts affects ability to breathe.

2) Explain what must be done to accommodate the medical need:

Food(s) or Formula to Omit:	Food(s) or Formula to Substitute:

Complete the back to provide additional details

Modified Texture: ☐ Not Applicable ☐ Chopped ☐ Ground ☐ Pureed

Modified Thickness of Liquids: ☐ Not Applicable ☐ Nectar ☐ Honey ☐ Spoon or Pudding Thick

Special Feeding Equipment: ☐ Not Applicable ☐ Equipment Needed: _____
(Example: large handled spoon, sippy cup, etc.)

Infants under one year of age must receive iron-fortified infant formula or breast milk unless a Diet Modification Request Form is on file.

Licensed prescribing medical professional:_____
(*Name, print or type)* (*Title)*

_____
(*Signature of medical professional)* *(Date)*

The program must make accommodations for disabilities. Accommodation is encouraged for other medical conditions.

The parent/guardian may request a nutritionally equivalent substitute for fluid milk without direction from a medical professional. This site chooses to offer this nutritionally equivalent product: _____. Check here if you would like to request the milk substitute listed in place of fluid milk and list the reason for the request. ❑ _____
USDA allows a parent/guardian to supply substitute foods. Check here if you wish to provide the substitute foods: ❑

Parent/Guardian signature:_____ Date: _____
(To document choices and permission to share with appropriate staff as needed to make accommodations.)

This institution is an equal opportunity employer and provider.

Developed by the Iowa Department of Education, Bureau of Nutrition and Health Services12/2021

Check the box in front of food groups that should NOT be served and list the foods to be served instead.

Lactose/milk – *Do not serve the items checked below:* ☐ Fluid milk as a beverage or on cereal? ¼ cup of fluid milk to be used on cereal? __yes __no ☐ Yogurt ☐ Milk based desserts such as ice cream and pudding ☐ Hot entrees with cheese as a prime ingredient such as grilled cheese, cheese pizza, or macaroni & cheese ☐ Cheese baked in products such as a casserole or on meat pizza ☐ Cold cheese such as string cheese or sliced cheese on a sandwich ☐ Milk in food products such as breads, mashed potatoes, cookies or graham crackers	**Serve these items instead:**
Soy - *Do not serve the items checked below:* ☐ Protein products extended with soy ☐ Processed items cooked in soy oil ☐ Food products with soy as one of the first three ingredients ☐ Food products with soy listed as the fourth ingredient or further down the list	**Serve these items instead:**
Egg - *Do not serve the items checked below:* ☐ Cooked eggs such as scrambled eggs or hard cooked eggs served hot or cold ☐ Eggs used in breading or coating of products ☐ Baked products with eggs such as breads or desserts	**Serve these items instead:**
Seafood – *Do not serve the items checked below:* ☐ Fish (Cod, tuna, tilapia, haddock, salmon, etc.) ☐ Shrimp ☐ Other:_____	**Serve these items instead:**
Peanuts – *Do not serve the items checked below:* ☐ Peanuts, individually or as an ingredient ☐ Foods containing peanut oil ☐ Foods items identified as manufactured in a plant that also handles peanuts	**Serve these items instead:**
Tree nuts – *Do not serve the items checked below:* ☐ All nuts ☐ Food items identified as manufactured in a plant that also handles nuts ☐ Other: _____	**Serve these items instead:**
Grains – *Do not serve the items checked below:* ☐ Foods containing wheat ☐ Foods containing gluten ☐ Oats ☐ Other: _____	**Serve these items instead:**