Health Requirements For Children Entering School

Mandatory Immunizations: **Preschool and Kindergarten**

Preschool and Kindergarten students are required by Iowa law to submit an *Iowa Department of Public Health Certificate of Immunization* to the school *prior to the first day of class*. School Officials cannot allow your child to attend school unless they have an Immunization Certificate completed or a Certificate of Immunization Exemption on file.

Mandatory Physical Exam and Lead Testing: **Preschool and Kindergarten**

Students enrolling in Preschool and Kindergarten are required by Iowa law to have a physical examination by a licensed physician and provide proof of such exam to the school district. It is also mandatory that children must provide proof of a blood lead test prior to starting kindergarten. A physical form is attached for your child's physician to use to document the physical exam and lead test results. **If your child has had a physical in the last 12 months, it is acceptable to have their primary healthcare provider complete the physical form reflecting that visit and submit it for this requirement.**

Mandatory Dental Screening: **Kindergarten**

It is mandatory for children enrolling in Kindergarten to present documentation of a dental screening to their school. **The attached form is required to be completed by a Physician or Dentist and returned to the school.** For elementary students, a screening that is done between the ages of 3-6 years old is acceptable. Local Dentists include Dr Klein, Dr Hanneman and Dr Stuefen. If your child does not have dental insurance, our community resources include Benton County I-Smile, St. Luke's Dental Health Center, or the University of Iowa Dental Clinic.

Mandatory Vision Screening: **Kindergarten**

It is now required that all children entering Kindergarten receive a complete eye health exam prior to starting school. This is an important step to assessing a child's vision health, and how good vision relates to a child's ability to learn. A student vision form is included for your health care provider or eye doctor to complete upon examination. **Please return completed form to school.**

Vinton-Shellsburg Community School District
Elementary School Physical

Child's Name: _____ Birthdate: _____

Allergies: _____ Medications: _____

Past Medical History/Health Concerns: _____

_____

Height: _____ Weight: _____ BMI: _____ BP: _____ Pulse: _____

Vision Screening Results: Right: _____ Left: _____ Both: _____

Blood Lead Screening Results: _____

Immunizations Current: _____ Referrals: _____

Head/Scalp: _____ Chest: _____

Eyes: _____ Heart: _____

Ears: _____ Lungs: _____

Mouth: _____ Abdomen: _____

Nose/Sinus: _____ Extremities: _____

Neck: _____ Spine/Back: _____

Neuromuscular/Developmental: _____

Does this child require any special accommodations? _____
If yes, please explain: _____

I have examined _____ and have found that he/she is physically and emotionally able to participate in Vinton-Shellsburg CSD Elementary School Program.

Physician Signature: _____ Date: _____

Physician's Printed Name: _____

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.

Iowa Department of Public Health
CERTIFICATE OF VISION SCREENING

RETURN COMPLETED FORM TO CHILD'S SCHOOL.

Student Information (please print)

Student Last Name:	Student First Name:	Birth Date (M/D/YYYY):
Parent/Guardian Telephone Number:	Student Address:	
Zip Code:		

Screening Information (vision 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: _____

Results (visual acuity):

Right Eye_____ Left Eye_____

Overall Result (Please select one):

Pass ○ or Fail ○

Referral to eye health professional (Please select one):

Yes ○ or No ○

Screening Provider: _____

Provider Business Name/Source of Screening: (please print) _____

Provider Name: (please print) _____ Phone: _____

Signature and 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 no later than six months after the date of the child's enrollment in Kindergarten.

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 3rd grade and no later than six months after the date of the child's enrollment in 3rd grade.

RETURN COMPLETED FORM TO CHILD'S SCHOOL.

Iowa Department of Public Health • Bureau of Family Health
FAX 515-242-6013 • 866-383-3826 • www.idph.state.ia.us