AQUIN ELEMENTARY

KINDERGARTEN REGISTRATION DATA

NAME_____ _____ _____
FAMILY FIRST (BAPTISMAL, PLEASE) MIDDLE

DATE OF BIRTH_____ RELIGION_____

PARENT/GUARDIAN_____ _____
(FATHER) (MOTHER-MAIDEN NAME ALSO)

ADDRESS_____ _____ _____ _____
STREET/P.O. BOX CITY STATE ZIP

TOWNSHIP_____SECTION_____HOME PHONE_____

CELL PHONE_____ EMAIL_____

BAPTISM DATE_____CHURCH WHERE BAPTIZED_____CITY & STATE_____
**Please provide copy of baptismal certificate if not baptized within the St. Thomas Aquinas Pastorate

** If not baptized, do you plan to receive the sacraments of Baptism, Reconciliation and First Communion in the future? ____YES _____NO

SCHOOL DISTRICT_____ PRESENT PARISH_____

This information is needed for your child's permanent office folder.

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If birth parents have two separate addresses and communication is to be sent to a place other than the child's primary place of residence, please complete this part.

PARENT: _____

ADDRESS: _____

COMMENTS: _____

Revised 1/26/16

To be filled out by Doctor

Return at the August Open House

KINDERGARTEN HEALTH ASSESSMENT RECORD

Child's Name _____ Address _____ Birth date _____ M ___ F ___

(Last) (First) (MI)

Parent(s) or Guardian _____ Home Phone _____

(Father) (Mother)

Child's Physician _____ Dentist _____ Hospital of Choice _____

Medicine taken regularly _____ Condition which could affect school work _____

Diseases	Date	Operations/Injuries	Date	Immunizations	1	2	3	4	5	6
Chicken Pox				DPT						
Convulsions				DT						
Hepatitis				Td						
Mononucleosis				OPV						
Pneumonia		Allergies		HbCV (Hib)						
Rheumatic Fever				MMR						
Strep Throat				HBV (Hepatitis B)						
		Birthmarks		Varicella						
				Exemptions						

PHYSICAL EXAMINATION

Date:	Height	Weight	Lab Work	Vision			
General Appearance			Hgb.:	With Glasses		No Glasses	
Posture	Blood Pressure:		Hct.:	Right	Left	Right	Left
Nutrition	TB Test	Date: Positive Negative	RBC:				
Skin			Urinalysis				
Feet	Lead Screening	Date: Result:					
Nose and Throat							
Eyes and Ears	COMMENTS by Physician:						
Tonsils and Glands							
Hearts and Glands							
Abdomen	*Signature of Examining Physician:*						
Congenital Anomalies							

1/2011

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			
Varicella Chicken Pox If patient has a history of natural disease write "Immune to Varicella"			
Pneumococcal PCV/PPV			
Meningococcal MCV4/MPSV4			
Hepatitis A			
Rotavirus			
Human Papilloma Virus HPV			
Other			

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 Bureau
515-281-3733 • 866-528-4020 • www.idph.state.ia.us/hpcdp/oral_health.asp
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
321 E 12th Street - Des Moines, IA 50319
FAX 515-725-1760 – Phone 800-383-3826
http://idph.iowa.gov/family-health/child-health/vision-screening