URBANDALE
COMMUNITY SCHOOL DISTRICT

Zdravstveni podaci za upis u školsko obdanište za 2018.–2019. školsku godinu

Kako bismo ubrzali proces upisa vašeg djeteta u školsko obdanište, htjeli bismo da sljedeće zdravstvene formulare, ako je ikako moguće, primimo najkasnije do 1. maja 2018. Imajte u vidu da zakon države Iowe nalaže roditeljima da prije upisa podnesu dokaz o obavljenoj vakcinaciji djeteta. Ukoliko vašem djetetu nedostaje jedna od potrebnih vakcina, ono će moći biti privremeno upisano u trajanju od 60 kalendarskih dana i to ako je primilo najmanje po jednu dozu svake propisane vakcine. Nakon isteka 60 dana, vaše će dijete biti isključeno sa nastave sve dok ne primi potrebne vakcine. Molimo da popunjene formulare dostavite u školu svog djeteta ili u centralni administrativni ured. Za dodatna pitanja slobodno se javite školskoj medinskoj sestri ili na e-mail adresu Sandy Walters walterss@urbandaleschools.com ili telefon (515) 457-5011.

Molimo vas da prilikom štampanja/podnošenja formulara: štampate svaku stranu formulara posebno na 1 stranici. Također, ako doneste originalne dokumente, mi ćemo napraviti kopije a vama vratiti originalne dokumente. Unaprijed hvala!

- **Ljekarski pregled:** Preporučuje se redovan ljekarski pregled. Molimo da priložite rezultate najnovijeg ljekarskog pregleda koristeći ili formular priložen u ovom paketu ili formular vaše ambulante.

- **Test olova u krvi:** Testiranje olova u krvi je propisano zakonom države Iowe za djecu prije navršenih 6 godina a prije upisa u školu. Molimo da od ljekara tražite kopiju laboratorijskih rezultata. Test se najčešće rutinski obavlja kad je dijete staro oko godinu dana.

- **Potvrda o obavljenom stomatološkom pregledu:** Pregled zuba treba biti obavljen u dobi između 3 i 6 godina i propisan je zakonom države Iowe. Molimo da vaš zubar popuni potvrdu o obavljenom stomatološkom pregledu priloženu u ovom paketu. Potvrdu mogu izdati i zubari sa sljedećim titulama: MD/DO, PA, RDH, RN/ARNP.

- **Pregled vida:** Obavezan je pregled vida. Molimo da priložite formular o obavljenom pregledu vida koji je u sastavu paketa.

- **Zdravstveni indeks učenika:** Molimo da popunite formular priložen u ovom paketu kako bismo saznali o eventualnim zdravstvenim probemima vašeg djeteta.

- **Potvrda o vakcinaciji:** Ovu potvrdu možete dobiti od svog doktora a možete koristiti i priloženi formular. Molimo da potvrdu o dosadašnjoj obavljenoj vakcinaciji priložite najkasnije do 1. maja čak i u slučaju da vaše dijete još nije primilo vakcine propisane za četvorogodišnjake .

Dobrodošlica polaznicima vrtića od medicinskih sestara distrikta Urbandale

Poštovani roditelji/staratelji,

Dobro došli u školski vrtić! Kao medicinske sestre školskog okruga mi smo zadužene da u partnertsvu s vama promovišemo zdravlje i sigurnost vaše djece. U prilogu vam za vašu lakšu evidenciju dostavljamo obrazac sa listom smetnji kao i kopije zdravstvenih dokumenta potebnih za vaše dijete. Molimo da popunjenu dokumentaciju dostavite medicinskoj sestri u školi koje će pohađati vaše dijete do **1. maja**.

Imajte u vidu da Zakon države Iowe nalaže roditeljima da podnesu **dokaz o obavljenoj propisanoj vakcinaciji prije upisa u školu**. Ukoliko vašem djetetu nedostaje jedna od propisanih vakcina, ono će moći biti privremeno upisano u trajanju od 60 kalendarskih dana i to ako je primilo po jednu dozu od svake propisane vakcine. **Nakon isteka 60 dana, vaše dijete će biti isključeno sa nastave sve dok ne primi potrebne vakcine.**

Pored toga, molimo da se javite školskoj medicinskoj sestri (u produžetku pogledajte informacije za kontakt) za eventualne zdravstvene potrebe ili smetnje vašeg djeteta. Ovo se odnosi na lijekove, astmu, diabetes, teške alergije, konvulzije, posebne dijetalne potrebe ili bilo koje druge smetnje koje mogu uticati na vaše dijete dok je pod našim nadzorom u školi. Htjele bismo da iskustvo vašeg djeteta u školi bude što je moguće zdravije i bezbjednije!

Radujemo se zajedničkoj saradnji s vama i vašim djetetom!

Stephanie Barron, RN, BSN
Rolling Green Elementary 515-457-5903
barrons@urbandaleschools.com

Susan Bruns, RN, BSN
Olmsted Elementary 515-457-5853
Jensen Elementary 515-457-5103
brunss@urbandaleschools.com

Jennifer Villegas, RN, BSN
Valerius Elementary 515-457-6503
Karen Acres Elementary 515-457-5703
villegasj@urbandaleschools.com

Heidi York, RN, BSN
Webster Elementary 515-331-8603
yorkh@urbandaleschools.com

Cilj misije medicinskih sestara UCSD-a:
Povećati obrazovni potencijal učenika podsticanjem optimalnog zdravlja i blagostanja.

Urbandale Community School District
Physical Examination

To be completed by physician

Student's Name	Birthdate M/ F
Parent's Name	Phone
Physician's Name	Phone

	Comments		Comments
Allergies: Food		Diabetes	
Allergies: Medicine		Hospitalization	
Allergies: Other		Illnesses	
Asthma		Injuries	
Bleeding Problems		Seizures	
Cancer		Surgery	

Height	Weight	BP	Hemoglobin	Lead Screen	Vision (Right)	Vision (left)	Corrective Lenses	Hearing
					20/	20/		

	Normal (✓)	Abnormal (✓)	Comments (required for abnormal)
Skin			
Hair & Scalp			
Eyes			
Ears			
Nose			
Mouth / Dental			
Lymph nodes			
Cardiovascular			
Respiratory			
Gastrointestinal			
Genitourinary			
Neurological			
Musculoskeletal			
Endocrine			
Spinal Examination			
Nutritional Status			
General Appearance			
Developmental			
Other			

Medications _____

Activity Restrictions _____

Conditions that might affect school performance _____

*****IMMUNIZATION CARD MUST BE ATTACHED TO THIS PHYSICAL*****

Physician's Signature _____ **Date** _____

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.

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.**

The following organizations recommend the use of the Student Vision Card

IOWA OPTOMETRIC ASSOCIATION

Iowa PTA everychild. onevoice.

Prevent Blindness Iowa

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

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 ☐ Near vision only
☐ Distance vision only ☐ As needed

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

Dr. Name: (Please Print) _____

Date_____ Signature_____

11/13

Urbandale Community School District
New Student Health Information

Completion of this form is required at registration and before admission to Urbandale Schools for all new students. The immunization record must also be reviewed.

Name_____ Grade_____

Does the student have:	**No**	**Yes**	**If yes, please explain**
ADD/ADHD			
Allergies (Foods, meds, other)			
Asthma/Reactive airway disease			
Braces/retainer			
Diabetes			
Fainting episodes			
Glasses/contacts/vision concerns			
Hearing concerns/hearing aids			
Heart concerns			
Intestinal or stomach concerns			
Kidney/bladder concerns			
Medical Procedures needed at school			
Medications (Name of med, given at home or school, dose, reason)			
Migraines/headaches			
Orthopedic devices			
Positive TB test			
Scoliosis			
Seizures			
Serious accidents in past year			
Skin problems			
Sleeping concerns			
Speech problems			
Surgeries in past year			
Weight problems			
Other			

Emergency information must be completed on the registration form. Parents are responsible for updating emergency information and the program of care.

I understand that all medical information is confidential and give permission to share this information on a professional basis with school personnel when deemed necessary by the school nurse.

Parent/Guardian_____ Date_____

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 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			

January 2013

IMMUNIZATION REQUIREMENTS

Applicants enrolled or attempting to enroll shall have received the following vaccines in accordance with the doses and age requirements listed below. If, at any time, the age of the child is between the listed ages, the child must have received the number of doses in the "Total Doses Required" column.

Institution	Age	Vaccine	Total Doses Required
Licensed Child Care Center	Less than 4 months of age	This is not a recommended administration schedule, but contains the minimum requirements for participation in licensed child care. **Routine vaccination begins at 2 months of age.**	
	4 months through 5 months of age	Diphtheria/Tetanus/Pertussis	1 dose
		Polio	1 dose
		haemophilus influenzae type B	1 dose
		Pneumococcal	1 dose
	6 months through 11 months of age	Diphtheria/Tetanus/Pertussis	2 doses
		Polio	2 doses
		haemophilus influenzae type B	2 doses
		Pneumococcal	2 doses
	12 months through 18 months of age	Diphtheria/Tetanus/Pertussis	3 doses
		Polio	2 doses
		haemophilus influenzae type B	2 doses; or 1 dose received when the applicant is 15 months of age or older.
		Pneumococcal	3 doses if the applicant received 1 or 2 doses before 12 months of age; or 2 doses if the applicant has not received any previous doses or has received 1 dose on or after 12 months of age.
	19 months through 23 months of age	Diphtheria/Tetanus/Pertussis	4 doses
		Polio	3 doses
		haemophilus influenzae type B	3 doses, with the final dose in the series received on or after 12 months of age, or 1 dose received when the applicant is 15 months of age or older.
		Pneumococcal	4 doses; or 3 doses if the applicant received 1 or 2 doses before 12 months of age; or 2 doses if the applicant has not received any previous doses or has received 1 dose on or after 12 months of age.
		Measles/Rubella[1]	1 dose of measles/rubella-containing vaccine received on or after 12 months of age; or the applicant demonstrates a positive antibody test for measles and rubella from a U.S. laboratory.
		Varicella	1 dose received on or after 12 months of age if the applicant was born on or after September 15, 1997, unless the applicant has had a reliable history of natural disease.
	24 months and older	Diphtheria/Tetanus/Pertussis	4 doses
		Polio	3 doses
		haemophilus influenzae type B	3 doses, with the final dose in the series received on or after 12 months of age; or 1 dose received when the applicant is 15 months of age or older. Hib vaccine is not indicated for persons 60 months of age or older.
		Pneumococcal	4 doses if the applicant received 3 doses before 12 months of age; or 3 doses if the applicant received 2 doses before 12 months of age; or 2 doses if the applicant received 1 dose before 12 months of age or received 1 dose between 12 and 23 months of age; or 1 dose if no doses had been received prior to 24 months of age. **Pneumococcal vaccine is not indicated for persons 60 months of age or older.**
		Measles/Rubella[1]	1 dose of measles/rubella-containing vaccine received on or after 12 months of age; or the applicant demonstrates a positive antibody test for measles and rubella from a U.S. laboratory.
		Varicella	1 dose received on or after 12 months of age if the applicant was born on or after September 15, 1997, unless the applicant has had a reliable history of natural disease.
Elementary or Secondary School (K-12)	4 years of age and older	Diphtheria/Tetanus/ Pertussis[4, 5]	3 doses, with at least 1 dose of diphtheria/tetanus/pertussis-containing vaccine received on or after 4 years of age if the applicant was born on or before September 15, 2000[2]; or 4 doses, with at least 1 dose of diphtheria/tetanus/pertussis-containing vaccine received on or after 4 years of age if the applicant was born after September 15, 2000, but before September 15, 2003[2]; or 5 doses with at least 1 dose of diphtheria/tetanus/pertussis-containing vaccine received on or after 4 years of age if the applicant was born on or after September 15, 2003[2, 3]; and 1 time dose of tetanus/ diphtheria/acellular pertussis-containing vaccine (Tdap) for applicants in grades 7 and above, if born on or after September 15, 2000; regardless of the interval since the last tetanus/diphtheria containing vaccine.
		Polio[7]	3 doses, with at least 1 dose received on or after 4 years of age if the applicant was born on or before September 15, 2003; or 4 doses, with at least 1 dose received on or after 4 years of age if the applicant was born after September 15, 2003.[6]
		Measles/Rubella[1]	2 doses of measles/rubella-containing vaccine; the first dose shall have been received on or after 12 months of age; the second dose shall have been received no less than 28 days after the first dose; or the applicant demonstrates a positive antibody test for measles and rubella from a U.S. laboratory.
		Hepatitis B	3 doses if the applicant was born on or after July 1, 1994.
		Varicella	1 dose received on or after 12 months of age if the applicant was born on or after September 15, 1997, but born before September 15, 2003, unless the applicant has had a reliable history of natural disease; or 2 doses received on or after 12 months of age if the applicant was born on or after September 15, 2003, unless the applicant has a reliable history of natural disease.[8]

[1] Mumps vaccine may be included in measles/rubella-containing vaccine.

[2] DTaP is not indicated for persons 7 years of age or older, therefore, a tetanus-and diphtheria-containing vaccine should be used.

[3] The 5th dose of DTaP is not necessary if the 4th dose was administered on or after 4 years of age.

[4] Applicants 7 through 18 years of age who received their 1st dose of diphtheria/tetanus/pertussis-containing vaccine before 12 months of age should receive a total of 4 doses, with one of those doses administered on or after 4 years of age

[5] Applicants 7 through 18 years of age who received their 1st dose of diphtheria/tetanus/pertussis-containing vaccine at 12 months of age or older should receive a total of 3 doses, with one of those doses administered on or after 4 years of age.

[6] If an applicant received an all-inactivated poliovirus (IPV) or all-oral poliovirus (OPV) series, a 4th dose is not necessary if the 3rd dose was administered on or after 4 years of age.

[7] If both OPV and IPV were administered as part of the series, a total of 4 doses are required, regardless of the applicant's current age.

[8] Administer 2 doses of varicella vaccine, at least 3 months apart, to applicants less than 13 years of age. Do not repeat the 2nd dose if administered 28 days or greater from the 1st dose. Administer 2 doses of varicella vaccine to applicants 13 years of age or older at least 4 weeks apart. The minimum interval between the 1st and 2nd dose of varicella for an applicant 13 years of age or older is 28 days.

Immunization Clinics

For your convenience, there are several agencies in the Des Moines area that offer immunizations for free or at reduced rates. Please call ahead for an appointment.

Polk County Health Department 1907 Carpenter Avenue, Des Moines, IA 515-286-3798 Appointment required Monday-Friday	DMU Free Mobile Clinic Various locations around Des Moines via mobile unit, including homeless camps and shelters 515-271-1374 1st & 3rd Sundays of the month: 9:00 – 11:00 am; occasional Saturdays
Broadlawns Pediatric 1801 Hickman, Des Moines, IA 515-282-2331 Appointment needed Financial assistance available	House of Mercy 1409 Clark Street, Des Moines, IA 515-643-6525 Appointment preferred; no fee Monday-Friday: 9:00 am – 11:45 am
Christ the King Free Clinic 5711 S.W. 9th Street, Des Moines, IA 515-285-2888 Mondays: 7:00 – 9:00 pm Wednesdays (Pediatric Clinic): 7:00-9:00 pm	Jim Ellefson Free Medical Clinic 1607 East 33rd Street, Des Moines, IA 515-266-7622 Tuesdays: 1:00 – 4:00 pm Thursdays: 5:30 – 8:30 pm
Mae E. Davis Free Medical Clinic Eddie Davis Community Center 1312 Maple Street, West Des Moines, IA 515-277-1103 Tuesdays: 7:00-9:00 pm	Margaret Cramer Clinic First Assembly of God Church 2725 Merle Hay Road, Des Moines, IA 515-279-9766, ext. 42 Thursdays: 6:00-8:00 pm Patient registration: 5:30 pm – 7:00 pm
Le Clinicia de la Esperanza United Mexican-American Community Center 828 S.E. Scott Avenue, Des Moines, IA 515-244-6162 Monday, Wednesday, Thursday: 8:00 am – 5:00 pm Tuesday: 8:00 am – 7:00 pm Friday: 8:00 am – 3:00 pm Appointments needed Spanish translation available at all times	Grace United Methodist Church Free Clinic 3700 Cottage Grove, Des Moines, IA 515-255-2131 Tuesdays: 5:30 pm – 7:00 pm Patient registration: 5:00 – 7:00 pm
Corinthian Family Health Free Clinic 814 School Street, Des Moines, IA 515-243-4073 Saturdays: 9:00 am – 12:00 pm	Islamic Center of Des Moines Free Medical Clinic 6201 Franklin Avenue, Des Moines, IA 515-255-0212 1st & 3rd Saturdays of the month: 9:00 – 11:00 am
Holy Family School Free Clinic 1265 East 9th Street, Des Moines, IA 515-262-7466 1st Monday of the month: 7:00 – 9:00 pm	