Southwest Valley Schools

Corning Campus

904 8th Street

Ph. 641-322-4242 **Corning, IA 50841** **FAX: 641-322-4243**

Dear Parents,

The following checklist has been compiled to assist you in getting your child ready for school in the fall. The items listed below are required by the Iowa Department of Public Health and need to be completed and returned to the school by August 2023.

____1. Health Information Form

____2. Physical (mandatory)

____3. Complete Immunization information (including dates and sources of immunizations)

____4. Dental screening - a valid screening must have been performed after the age of 3 AND the Certificate of Dental Screening is the only acceptable form

____5. Vision screening - a valid screening must have been performed within 1 year of enrollment

____6. Special forms to be completed by your child's healthcare provider are required if your child has food allergies, requires a special diet, requires an epipen, and/or uses an inhaler. Please ask the school nurse for any forms your child may require.

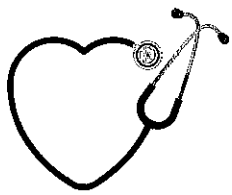
I encourage you to make your appointments at your healthcare provider, dentist, and eye doctor early because it may take time to get an appointment.

Sincerely,

Lindsey Hogan, RN, BSN
Southwest Valley Schools, East Campus

Health Information

(to be completed by parent/guardian)



Student's Name _____

Date of Birth _____

Because we want your child to have the best/most complete health care, you may assist us by answering the following questions:

Physician _____ Physician's Phone _____

Physician's Address _____

Dentist _____ Dentist Phone _____

Allergies (List all food, medicine, environmental, seasonal, etc) _____

_____

Does your child require medication at school? If so, please list _____

_____

Does your child require medication at home? If so, please list _____

_____

Does your child have any of the following? (please circle)

Vision Problems Hearing Problems Corrective Lenses Ear Tubes Hearing Aids

List any diseases, operations, or injuries in the past year _____

Does your child require any special services at school? Are there any known physical conditions or limitations that the school should be aware? If so, please explain _____

_____

Please share the above health information with my child's teacher and any other person within the school district who has direct contact with my child.

Parent Signature _____ Date _____

Preschool/Kindergarten Physical Form

Corning Elementary
1012 10th Street
Corning, IA 50841
641.322.4020

Student's Name_____

Birthdate_____

Parent's Name_____ Phone Number_____

Family Physician _____ Physician Phone_____

Information to be completed by the physician/health care provider:

Height (inches)_____ Weight (lbs)_____

Lead Test Date / Result _____

Does the child have any allergies? Yes No Please Explain_____

Does the child have chronic illness? Yes No Please Explain_____

Does the child have ear tubes? Yes No

Has the child had chickenpox? Yes No Disease Date_____

Are the child's immunizations up-to-date? Yes No If no, please explain_____

Does the physical exam reveal any abnormalities or limitations? Yes No

Please Explain _____

Is the child on any medications? Yes No

Please list medications & times given:_____

Are there any restrictions, accommodations and/or recommendations to help this child to be successful in the school environment?

_____

_____

_____

Physician/Health Care Provider 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 • http://idph.iowa.gov/ohds/oral-health-center
A designee of the local board of health or Iowa Department of Public Health may review this certificate for survey purposes.

8/17/2016

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 – Breau 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

12/14/2015

Dear Parents,
We need to ask permission for students to have sunscreen or insect repellent applied when the weather and environment for outdoor play require these measures. Please mark your preferences below and return the form with your child's enrollment packet.

Thanks!

Mrs. Ayers

Child's name _____

_____ I **GIVE** my permission for sunscreen greater than SPF 15 to be applied to protect my child.
_____ I **DO NOT GIVE** my permission for sunscreen greater than SPF 15 to be applied to protect my child.

_____ I **GIVE** my permission for insect repellent containing DEET to be applied to protect my child.
_____ I **DO NOT GIVE** my permission for insect repellent containing DEET to be applied to protect my child.

_____ _____
Parent Signature Date

Preschool Goal Sheet Child's Name_____

Please mark what specific goals you would like your child to work on this year at preschool.

	EDUCATION
	Match/Name Colors
	Match/Name Shapes
	Names body parts
	Counts
	Sorts objects
	Recognize numbers 1-10
	LANGUAGE
	Speaks clearly
	Expresses needs/wants appropriately
	States first and last name
	Recognizes/prints name
	Follows directions
	Recognize alphabet: sounds/formation
	NUTRITION
	Tries a variety of foods
	Uses manners at the table
	Pours liquids
	Uses utensils correctly
	Serves self
	Remains at table

	MENTAL/SOCIAL
	Shares with others
	Takes turns
	Uses words not actions (hit, kick, etc.)
	Stay with an activity for 4-10 minutes
	Follow classroom rules
	Helps with clean up
	Use an inside voice
	PHYSICAL
	Use bathroom independently
	Use Kleenex when needed
	Dresses self
	Washes hands-before meal/snack
	Holds a pencil/crayon correctly
	Use glue appropriately
	Hold scissors correctly
	OTHER

Parent comments:

Photo Release Form

Please be advised that your child may be photographed or videotaped at various school sponsored events. If you would like your child's photo to appear on our class and or school Facebook pages please sign and return this form.

Please sign and return this form.

_____ **Yes**, I give permission for my child's photograph and or video to be posted on our class or school Facebook pages.

_____ **No**, my child's photograph and or video may not be posted on our class or school Facebook pages.

_____

_____

Signature Date

Consent and Release of Information

MATURA Action Corporation

Child's Name:					Age:	Date of Birth:
Address:					Cell Phone: Other Phone:	
☐ Male ☐ Female	Race:	☐ White ☐ Black	☐ Hispanic ☐ Asian/Pacific Islander	☐ Native American ☐ Other	☐ Undetermined/ Unknown	
Child's Physician:					Child's Dentist:	
If applicable, child's Medicaid ID number:						

☐ **YES**, I give permission for my child to receive a dental screening and fluoride varnish application.

☐ **NO**, I do not give permission for my child to receive a dental screening and fluoride varnish application.

Please answer the following questions:

1. Has your child seen a dentist within the past 12 months? ☐ Yes ☐ No
2. My child's most recent dental visit was within the past: (please check one)
   ☐ 6 months ☐ 1 year ☐ 3 years ☐ 5 years ☐ has never seen a dentist
3. How do you pay for your child's dental care? (please check one)
   ☐ Self ☐ Medicaid/Title XIX ☐ ***hawk-i*** ☐ Private dental insurance ☐ Other
4. List any concerns you have about your child's mouth or teeth: _____
5. Has your child seen a physician within the past 12 months? ☐ Yes ☐ No
6. Is your child currently taking any medications? ☐ Yes ☐ No Explain: _____
7. Does your child have any allergies? ☐ Yes ☐ No Explain: _____
8. Are your child's immunizations up to date? ☐ Yes ☐ No Explain: _____
9. How do you pay for your child's medical care?
   ☐ Self ☐ Medicaid/Title XIX ☐ ***hawk-i*** ☐ Private medical insurance ☐ Other

I consent to MATURA Action Corporation use of email and texting to send me scheduling and child health services information.
☐ Yes ☐ No Email address: _____

- I was offered a Notice of Privacy Practices.
- I understand that this consent for services is valid for one (1) year unless withdrawn in writing by parent, guardian or client (if of legal age).
- I understand that the services that will be received do not take the place of regular dental checkups at a dental office.
- I understand that these services are provided under the Iowa Department of Public Health, Maternal and Child & Adolescent Health Program.
- I understand records created and maintained as part of this program are the property of the Iowa Department of Public Health.
- I understand that the information from these records may be shared with the Iowa Department of Public Health and its agents and Title V contractors, Iowa Medicaid Enterprise, or designee for audit and quality improvement purposes or other legally authorized purposes.

Parent/Guardian Signature Date

I voluntarily authorize MATURA Action Corporation to release, obtain, or exchange information manually and/or via an electronic platform maintained by TAVHealth with the following Title V MCAH agenicies, Preschools, Physicians, dentists, Head Start. This release does not authorize disclosure of material protected by federal and/or state law applicable to substance abuse, mental health and/or AIDS-related information.

Parent/Guardian Signature Date

Corning Preschool
Release of Health Information

Student's Name _____

Any health information concerning my child may be shared with the following staff:

Ayers, Christy - Teacher
Stewart, Krist - Para
Hogan, Lindsey - Nurse
Rhamy, Katie – Sub Nurse
Rhamy, Marci – Sub Nurse
Thomas, Allison – Principal
Shuler, Dawn - Secretary

Parent Signature _____Date_____

Photography Permission Slip

Name of Child
Participant:_____

Name of Parent or Guardian
(Releaser):_____

Name of Teacher:_____

This teacher is seeking or has earned a grant through **DonorsChoose.org**, a nonprofit organization serving public school students. At our website, www.DonorsChoose.org, teachers can request resources and experiences for their students, and individual donors can choose a request they want to fund. This teacher has taken the initiative to seek funding for an activity.

As a result, this teacher's class may receive resources for one or more requested student activities. In this event, we may show photographs of the activities taking place on our website at www.DonorsChoose.org, to the donor(s) who funded the request(s) as well as other visitors to our site. To help generate donor interest for this teacher's project(s), we may also display a picture featuring this teacher's class on our website for potential donors to view. In addition, we may allow our donors to display all photographs on their websites and social media channels and to otherwise use the photographs on their websites and social media channels and to otherwise use the photographs for publicity and promotional purposes.

With your signature below, you consent as follows:

- I am the legal parent or guardian (releaser) of the child participant named above. I hereby give permission for the participant to be photographed (with or without other classmates).
- I understand, agree, and give permission for DonorsChoose.org to display the photographs on the DonorsChoose.org website.
- I understand, agree, and give permission for DonorsChoose.org, its partners, and its donors to otherwise use photographs for promotional purposes.

Signature of Parent or Guardian (Releaser): _____

Date: _____

PLEASE RETURN THE COMPLETED, SIGNED FORM TO THE TEACHER AS SOON AS POSSIBLE. THANK YOU.

Dear Parents,

We would like to administer the BRIGANCE Early Childhood Screening at the beginning of the school year. This assessment will help to identify possible learning delays and giftedness. The information provided also shows the child's strengths and needs in language, motor, self-help, social-emotional, and cognitive skills. (Description from the Brigance curriculum).

Many of the skills shown in this assessment will help the teachers plan and individualize instruction for all preschool students. However, we would like to ask your permission to do the assessment and share information within our CCSP planning team. We will also make you aware of the results and how they could affect education.

Please feel free to keep the top half of this page and return the permission form below.

Thank you very much!

Sincerely,

Mrs. Ayers

Child's Name: _____ Date:_____

_____ I give permission for the BRIGANCE screening to be done with my child.

_____ I **do not** give permission for the BRIGANCE screening to be done with my child.

Parent's Signature: _____

Parent Request for Preschool

Student Name: _____

Child care provider:_____

We offer both a morning and afternoon session. These are mostly determined by bus route and trying to keep students from the same day care provider in the same session. We do our best to honor parent requests to the extent possible. Once the placements are determined, you will receive notice this summer as to which program your child will be attending. To help us in making the schedules, please provide this information:

1. Would you prefer morning or afternoon?

2. Where would your child be picked up in the mornings if they would attend the AM session?

3. Where would your child need to be dropped off or picked up at noon?

4. Where would your child be dropped off after school if in the PM session?

Note:
Morning session 8:15-11:15
Afternoon session 12:30-3:30