Esta sección completada por padres. La parte trasera debe ser completada por un proveedor de atención médica aprobado.

EVALUACIÓN DE SALUD PARA NIÑOS Y JÓVENES

Se requieren exámenes físicos para todos los estudiantes nuevos en las escuelas de Kansas y los estudiantes que ingresan a Kínder, 6 ° y 9 ° grado.

Nombre: ____ Fecha de Nacimiento: __________ Masculino/Femenino: ____

Dirección: ____Ciudad ________________Código Postal ______________

Padre/ Tutor: _______________________________________ Teléfono: Trabajo: _____________Casa: _______________

El niño vive con: _____________________________________ Teléfono: Trabajo: _____________Casa: _______________

Cuantos en el hogar: _________________________________ Oculista: ____

Médico: ____ Dentista: ____

HISTORIAL DE SALUD FAMILIAR A SER COMPLETADO POR EL PADRE / TUTOR

Códigos de Respuesta: M = Materno P = Paterno S = Hermanos NA = No Aplicable

Pregunta	Código	Comentario
¿Hay algún problema de enfermedad crónica en su familia como enfermedad cardiaca, diabetes, cáncer, convulsiones, enfermedad mental, abuso de sustancias u otros? Comentario?		
¿Algún miembro de la familia tiene un defecto de visión, pérdida de audición o deformidad de la columna vertebral? ¿Comentario?		

HISTORIAL DE NINOS/ADOLESCENTES

Códigos de Respuesta: Y = Si N = No NA = No Aplicable

Pregunta	Código	Comentario
Peso de Nacimiento:_______ ¿Hubo algún problema prenatal y de parto con el niño?		
¿Caminó, habló y desarrolló este niño a la hora habitual?		
¿Este niño / adolescente: Este niño camino, hablo y se desarrolló al tiempo normal?		
¿Usa algún medicamento, drogas o alcohol?		
¿Tiene un historial de hospitalizaciones, cirugías o visitas a la sala de emergencias?		
¿Tiene un historial de enfermedades / enfermedades infantiles?		
¿Tiene un historial de otras enfermedades contagiosas?		
Edad menarquia: ____ ¿Tiene un historial de problemas menstruales?		
¿Tiene un historial de problemas de visión, habla, audición o comunicación?		
¿Tiene un problema con estar cansado o hiperactivo?		
¿Tiene algún problema emocional o de comportamiento?		
¿Necesita ayuda especial en la escuela o guardería?		
¿Tiene problemas de sexualidad?		

Tiene alguna enfermedad crónica o problemas incapacitantes con:

Dolor de Cabeza: __ Convulsiones: __ Diabetes: __ Dolor de Oído: __ Espalda/Columna: __ Resfriado / Dolor de Garganta: __ Asma: __ Genitales: __ Oral / Dental: __ Alergias: __ Digestivo: __ Problemas de Extremidades: __ Urinario / Intestinal: __ Enfermedad Cardíaca/Pulmonar: __ Otro: ____

POR FAVOR, DESCRIBA ANTERIORMENTE LOS PROBLEMAS Y CUALQUIER OTRA PREOCUPACIÓN SOBRE LA SALUD.

____

POR FAVOR DE LISTAR LOS MEDICAMENTOS ACTUALES ____

This side to be completed by physician/approved healthcare provider

Name ____

Immunization: Record date of each dose received (mm/dd/yy)										
	1st	2nd	3rd	4th	5th	6th		1st	2nd	3rd
DTaP (Diphtheria, pertussis, tetnus)							MMR (Measles, Mumps, Rubella)			
Td/DT/Tdap							Hep B (Hepatitis B)			
OPV or IPV (Polio)							Varicella (Chicken Pox)			
HIB (Hemophilus influenza B)							Hep A			

The above immunizations have been verified by the following: ____

Signature of physician or other qualified person

PHYSICAL EXAMINATION: TO BE COMPLETED BY APPROVED HEALTH CARE PROVIDER.

Height	________	Weight	________	Hgb or Het	________
Pulse	________	Blood Pressure	________	Lead	________
Urinalysis	________	Sickle Cell	________	TB	________

Code Each Item as Follows: 0=No sig. findings 1=Significant findings	Code	Description of Findings
General Appearnace		
Integument		
Head - Neck		
EENT		
Oral - Dental		
Thorax		
Breasts		
Cardiovascular		
Abdomen		
Musculoskeletal		
Genitourinary		
Neurological		

SCREENING

1. Nutritional Evaluation - Results ____
2. Development: Type of screen ____________ Results ____
3. Speech: Type of screen ____________ Results ____
4. Hearing: Type of screen ____________ Results ________________________ Date of last screen ______________
5. Visioin: Type of screen ____________ Results ________________________ Date of last screen ______________

Significant Assessment Findings:

Recommendations: (to parents, teachers -- include any referrals)

Follow Up:

Anticipatory Guidance: (circle those discussed)

1. Safety
2. Nutrition
3. Parenting
4. Family Planning
5. Discipline
6. Immunizations
7. Hygiene
8. Lifestyle
9. Development
10. Behavior
11. Sexuality
12. Dental
13. Other

Comments:

RECOMMENDATIONS FOR PHYSICAL EDUCATION:

Full program ________ Restricted (explain) ____

No participation (explain) ____

Additional Information may be attached.

______________________ Date

________________________________ Signature of Physician or Nurse approved to perform health assessments

Medication may be given at school only with a signed physician order and brought to school in the original container.

KANSAS CERTIFICATE OF IMMUNIZATIONS (KCI)

This record is part of the student's permanent record and shall be transferred from one school to another as defined in Section 72-5209 (d) of the Kansas School Immunization Law (amended 1994.)

Student Name: ______________________ Address: ______________________

Parent or Guardian Name: ______________________ ______________________

Phone: ______________________ ______________________

Birthdate (MM/DD/YYYY): __________ SEX: [ ] MALE [ ] FEMALE Race: __________ Ethnicity: __________ County: __________

VACCINE	RECORD THE MONTH, DAY, AND YEAR THAT EACH DOSE OF VACCINE WAS RECEIVED						
	1st	2nd	3rd	4th	5th	6th	7th
DTaP/DT/Td/Tdap (Diphtheria, Tetanus, Pertussis) Required for school entry. Single Tdap required for grades 7-12. State Type	DT DTaP Td Tdap	DT DTaP Td Tdap	DT DTaP Td Tdap	DT DTaP Td Tdap	DT DTaP Td Tdap	DT DTaP Td Tdap	DT DTaP Td Tdap
Polio Required for school entry.						If additional doses are added, please initial the dose and sign below:	
HEP B (Hepatitis B) Required for school entry.							
Varicella (Chickenpox) Required for school entry. 2 doses grades K-4 & 7-9. One dose Grades 5-6 and 10-12 for school year 2013-2014.			Hx of Disease: Physician Signature:		Date of Illness:		
MMR (Measles, Mumps, and Rubella combined) Required for school entry.	MMR Me/Mu/Ru	MMR Me/Mu/Ru					
Influenza (Flu) Recommended annually for ages 6mo and older. Not required for school entry.							
HIB (Haemophilus Influenzae Type B) Required < 5 years of age for preschool or child care operated by a school.							
PCV (Pneumococcal Conjugate) Required < 5 years of age for preschool or child care operated by a school.							
HEP A (Hepatitis A) Required < 5 years of age for preschool or child care operated by a school.							
MCV4 (Meningococcal) Initial dose recommended at 11-12 years of age and booster dose recommended after 16 years of age. Not required for school entry.							
HPV (Human Papillomavirus) Recommended for males and females at 11-12 years of age. Not required for school entry.							
Rotavirus Recommended < 8 mo. Not required for school entry.							

DOCUMENTATION

KCI MAY ONLY BE SIGNED BY A PHYSICIAN (MD/DO), HEALTH DEPT, OR SCHOOL.

☐ I certify I reviewed this student's vaccination record and transcribed it accurate

Agency Name: ______________________

Authorized Representative: ______________________

Address: ______________________

The record presented was Date __________

☐ Kansas Immunization Record

☐ Other Immunization Record (Specify) ______________________

LEGAL ALTERNATIVES TO VACCINATION REQUIREMENTS "KSA 72-5209"

1. "Annual written statement signed by a licensed physician (Medical Doctor/M.D. or Doctor of Osteopathy/D.O.) stating the physical condition of the child to be such that the tests or inoculations would seriously endanger the life or health of the child." Medical exemption shall be validated annually by physician completion of KCI Form B and attachment to the KCI.

2. "Written statement signed by one parent or guardian that the child is an adherent of a religious denomination whose religious teachings are opposed to such tests or inoculations."

KANSAS IMMUNIZATION PROGRAM
1000 SW Jackson, Suite 075, Topeka, KS 66612-1274
PHONE 785-296-5591 FAX 785-296-6510
WEB SITE www.kdheks.gov/immunize

I give my consent for information contained on this form to be released to the Kansas Immunization Program for the purpose of assessment and reporting.

______________________ Parent/Legal Guardian's Signature __________ Date

Rev. 02/01/2013

KANSAS IMMUNIZATION REQUIREMENTS: Based on age of child as of September 1 of current school year.

As per Kansas Statute 72-5209, all children upon entry to school must be appropriately vaccinated. In each column below, vaccines are required for all ages listed in that column.

Ages 0-4
Recommended Schedule

Age	Vaccines
Birth	**HEP B**
2 Months	**DTaP/DT** **POLIO** **HEP B** **HIB** **PCV** **ROTAVIRUS**
4 Months	**DTaP/DT** **POLIO** **HIB** **PCV** **ROTAVIRUS**
6 Months	**DTaP/DT** **POLIO** **HEP B** **HIB** **PCV** **ROTAVIRUS**
12-15 Months	**MMR** **VAR** **HIB** **PCV** **HEP A**
15-18 Months	**DTaP/DT**
18-24 Months	**HEP A**

Recommendations are based on the ACIP recommended schedule.†

Ages 5-6

DTaP: 5 Doses

a) 4 week minimum interval between first 3 doses; 6 month interval between dose 3 and dose 4.
b) 4 doses acceptable if dose 4 given on or after the 4th birthday.
c) If dose 4 administered before 4th birthday, 5th dose must be given at 4-6 years of age.

POLIO - Grade K-2

a) 4 week minimum interval between first 3 doses; 6 month interval required between dose 3 and dose 4; one dose after 4th birthday
b) 3 doses acceptable if 4 weeks between dose 1 and 2; 6 months between dose 2 and 3; one dose after 4th birthday

POLIO - IPV/OPV Combination Schedule: 4 Doses required

a) 4 week minimum interval between first 3 doses; 6 month interval required between dose 3 and dose 4; one dose after 4th birthday
b) 3 doses not acceptable with combination schedule

Grades K-2, new students and students completing series must have 6 months between last two doses with one dose after 4th birthday.

MMR: 2 Doses

a) First dose on or after the 1st birthday.
b) 4 week minimum interval between doses.

VARICELLA: 2 Doses Grades K-4 for School Year 2013-2014

a) First dose on or after the 1st birthday.
b) Second dose must be given at least 28 days after first dose.
c) None required if prior varicella disease verified by physician.
d) Two doses are recommended for all children.

HEPATITIS B: 3 Doses

a) 4 week minimum interval between dose 1 and dose 2.
b) 8 week minimum interval between dose 2 and dose 3.
c) 16 week minimum interval between dose 1 and dose 3.
Dose 3 must be given after 24 weeks of age.

Ages 7 and Older

Tdap/Td:

3 doses if no history of any DTaP doses (a-b)

a) 4 week minimum interval between dose 1 and dose 2; first dose must be Tdap
b) 6 months between dose 2 and 3
c) Single dose of Tdap for an incomplete primary DTaP series
d) Single dose of Tdap required for Grades 7-12

POLIO

Grades 3-12

Polio - All IPV or OPV Schedule: 4 doses

a) 4 week minimum interval between doses, regardless of age given.

Polio - All IPV or OPV Schedule: 3 doses

a) 4 week minimum interval between each dose, with 1 dose given on or after the 4th birthday.

Polio - IPV/OPV Combination Schedule

a) Must be 4 doses with 4 weeks between doses

New students and students completing series must have 6 months between last two doses with one dose after 4th birthday.

MMR: 2 Doses

a) First dose on or after the 1st birthday.
b) 4 week minimum interval between doses.

VARICELLA: 2 Doses Grades 7-9 School Year 2013-2014
1 Dose Grades 5-6 and 10-12 School Year 2013-2014

a) First dose on or after the 1st birthday.
b) Second dose must be given at least 28 days after first dose.
c) None required if prior varicella disease verified by physician.
d) Two doses are recommended for all children.

HEPATITIS B: 3 Doses

a) 4 week minimum interval between dose 1 and dose 2.
b) 8 week minimum interval between dose 2 and dose 3.
c) 16 week minimum interval between dose 1 and dose 3.
d) Dose 3 must be given after 24 weeks of age.

† - The ACIP Schedules may be accessed at: http://www.cdc.gov/vaccines/recs/schedules

Vaccine doses given up to 4 days before the minimum interval or age may be considered valid.
With the exception of Hepatitis B vaccine, immunizations given before 6 weeks of age are not considered valid.
Half doses or reduced doses of vaccine are not considered valid.

ACIP - Varicella vaccine minimum interval less than 13 yrs is 3 months; 13 yrs and older is 4 weeks however, a 28 day interval regardless of age may be counted as valid. All doses must be after first birthday.

PARENTS AND/OR GUARDIANS ARE NOT AUTHORIZED TO COMPLETE KCI FORMS.

KCI FORM B - MEDICAL EXEMPTION is located at http://www.kdheks.gov/immunize/imm_manual_pdf/KCI_formB.pdf
BLANK VERSION OF KCI FORM is available at http://www.kdheks.gov/immunize/download/KCI_Form.pdf

A ROSTER WITH THE NAMES OF ALL EXEMPT STUDENTS SHOULD BE MAINTAINED. PARENTS OR GUARDIANS OF EXEMPT CHILDREN SHOULD BE INFORMED THAT THEIR CHILDREN SHALL BE EXCLUDED FROM SCHOOL IN THE EVENT OF AN OUTBREAK OR SUSPECTED CASE OF A VACCINE-PREVENTABLE DISEASE.