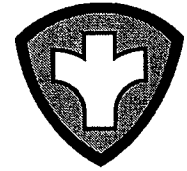




SCOTT COUNTY HEALTH DEPARTMENT
Administrative Center
600 W. 4th Street
Davenport, Iowa 52801-1030
Office: (563) 326-8618 Fax: (563)326-8774
www.scottcountyiowa.com/health



Public Health
Prevent. Promote. Protect.

Dear Parent/Guardian:

As you prepare to send your child to kindergarten this fall, there are many things to consider. In order for your child to be admitted to school, he/she is required **by Iowa Law** to have the following completed:

- ✓ An Iowa Certificate of Immunization (*form attached*)
- ✓ An Iowa Certificate of Dental Screening (*form attached*)
- ✓ A blood lead test before 6 years of age (*no form required*)
- ✓ Your child is **not** required to have a physical before entering school, but it is strongly encouraged.
- ✓ A green Student Vision Card is included in this packet per Iowa Law, but an eye exam is optional

Please contact me at 326-8658 if you have any questions.

*Kathy Andresen, MSN, RN, NCSN
School Health Consultant*



Iowa Department of Public Health CERTIFICATE OF DENTAL SCREENING

This certificate is not valid unless all fields are complete.

A designee of the local board of health or Iowa Department of Public Health may review this certificate for survey purposes.

Please Print:

Student's Last Name:		Student's First Name:		Birth Date (M/D/YYYY):	
Parent or Guardian Name:				Telephone (home):	
				(mobile):	
Address: Street			City:		County:
Name of School:			Grade Level:		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female

Treatment Needs (check ONE):

- Yes No **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.
- Yes No **Requires Dental Care** – tooth decay or a white spot lesion is suspected in one or more teeth.
- Yes No **Requires Urgent Dental Care** – obvious tooth decay is present in one or more teeth, the child is experiencing pain, or there is evidence of infection or injury.

Definitions:

Tooth decay: A visible cavity or hole in a tooth with brown or black coloration, or a retained root.

White spot lesion: A demineralized area of a tooth, usually appearing as a chalky, white spot or white line near the gum line. A white spot lesion is considered an early indicator of tooth decay, especially in primary teeth.

Date of Dental Screening: _____

Provider Type*:
 DDS RDH MD/DO PA Nurse *High school screening can only be provided by DDS or RDH.

Provider Name: _____ Provider Signature: _____

Business Address: _____

Business Phone: _____

**A screening does not replace an exam by a dentist.
Children should have a complete examination by a dentist at least once a year.**

Visual Acuity	At Distance	At Near
<input type="checkbox"/> Without correction	R20/	L20/
<input type="checkbox"/> With present correction	R20/	L20/
<input type="checkbox"/> With new correction	R20/	L20/

External Eye Health Normal Other **Internal Eye Health** Normal Other

Vision Analysis

R	L	
<input type="checkbox"/>	<input type="checkbox"/>	Normal eyesight
<input type="checkbox"/>	<input type="checkbox"/>	Nearsighted (myopic)
<input type="checkbox"/>	<input type="checkbox"/>	Farsighted (hyperopic)
<input type="checkbox"/>	<input type="checkbox"/>	Astigmatism
<input type="checkbox"/>	<input type="checkbox"/>	Amblyopia
<input type="checkbox"/>	<input type="checkbox"/>	Other _____

Eye teaming difficulty
 Crossed-eyes (strabismus)
 Eye focusing difficulty
 Sensitivity to light

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 _____

Eye Care Professional:

Please complete this postage paid portion of the Student Vision Card, detach and drop in the mail. This information will be used for data collection purposes only. Thank you!

Patient Grade _____ School _____ Town _____

Patients first visit to an eye doctor?

Yes No

Vision Correction Recommended?

Yes No

Eye Health

Please indicate if present

Amblyopia Strabismus

Refractive error Other _____
 (greater than +/-1.25)

Thank you!

Visual Acuity		At Distance		At Near	
<input type="checkbox"/> Without correction		R20/	L20/	R20/	L20/
<input type="checkbox"/> With present correction		R20/	L20/	R20/	L20/
<input type="checkbox"/> With new correction		R20/	L20/	R20/	L20/

External Eye Health Normal Other **Internal Eye Health** Normal Other

Vision Analysis

R	L		
<input type="checkbox"/>	<input type="checkbox"/>	Normal eyesight	<input type="checkbox"/> Eye teaming difficulty
<input type="checkbox"/>	<input type="checkbox"/>	Nearsighted (myopic)	<input type="checkbox"/> Crossed-eyes (strabismus)
<input type="checkbox"/>	<input type="checkbox"/>	Farsighted (hyperopic)	<input type="checkbox"/> Eye focusing difficulty
<input type="checkbox"/>	<input type="checkbox"/>	Astigmatism	<input type="checkbox"/> Sensitivity to light
<input type="checkbox"/>	<input type="checkbox"/>	Amblyopia	
<input type="checkbox"/>	<input type="checkbox"/>	Other _____	

Vision Correction Recommendations

<input type="checkbox"/> No correction necessary	<input type="checkbox"/> To be worn for:	
<input type="checkbox"/> No change in present prescription	<input type="checkbox"/> Constant wear	<input type="checkbox"/> Near vision only
<input type="checkbox"/> New prescription needed	<input type="checkbox"/> Distance vision only	<input type="checkbox"/> As needed

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

Dr. Name: (Please Print) _____

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Patients first visit to an eye doctor?

Yes No

Vision Correction Recommended?

Yes No

Eye Health

Please indicate if present

Amblyopia Strabismus

Refractive error Other _____
(greater than +/-1.25)

Thank you!



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, 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 <i>DTaP/DTP/DT/ Td/Tdap</i>			
Polio <i>IPV/OPV</i>			
Measles, Mumps, Rubella <i>MMR</i>			
Haemophilus influenzae type b <i>Hib</i>			
Hepatitis B			
Varicella Chicken Pox <small>If applicant has a history of natural disease write "Immune to Varicella"</small>			
Pneumococcal <i>PCV/PPV</i>			

	Vaccine	Date Given	Doctor / Clinic / Source
Meningococcal <i>MCV4/MPSV4</i>			
Hepatitis A			
Rotavirus			
HPV			

Licensed Child Care Requirements	
2 through 5 months 1 dose Diphtheria/Tetanus/Pertussis 1 dose Polio 1 dose Hib	6 through 14 months 2 doses Diphtheria/Tetanus/Pertussis 2 doses Polio 2 doses Hib
15 through 18 months 3 doses Diphtheria/Tetanus/Pertussis 3 doses Polio 3 doses Hib with the final dose \geq 12 months of age, or 1 dose \geq 15 months of age 1 dose Measles/Rubella \geq 12 months of age	19 months and older 3 doses Diphtheria/Tetanus/Pertussis 3 doses Polio 3 doses Hib with the final dose \geq 12 months of age, or 1 dose \geq 15 months of age 1 dose Measles/Rubella \geq 12 months of age 1 dose Varicella \geq 12 months of age if born on or after September 15, 1997, or a reliable history of natural disease
Elementary/Secondary School Requirements	
4 years of age and older 4 doses Diphtheria/Tetanus/Pertussis if born after September 15, 2000; or 3 doses if born on or before September 15, 2000. One of these doses must be received \geq 4 years of age. 3 doses Polio, with 1 dose \geq 4 years of age. 2 doses Measles/Rubella or positive antibody test for measles and rubella. First dose \geq 12 months of age; second dose no less than 28 days after the first dose 3 doses Hepatitis B if born on or after July 1, 1994 1 dose Varicella \geq 12 months of age if born on or after September 15, 1997, or a reliable history of natural disease	