

COMMONWEALTH OF KENTUCKY CERTIFICATE OF IMMUNIZATION STATUS

Certificate Issuing Office Name and Address

Name of Child: _____ Birthdate: _____
(Last) (First) (Middle) (Suffix) (MM/DD/YYYY)

Name of Parent: _____
(Last) (First) (Middle) (Suffix)

Address: _____
(Street) (City) (State) (Zip Code)

VACCINE	DOSE 1 MM/DD/YYYY	DOSE 2 MM/DD/YYYY	DOSE 3 MM/DD/YYYY	DOSE 4 MM/DD/YYYY	DOSE 5 MM/DD/YYYY
Hepatitis B	/ /	/ /	/ /	/ /	
Alt. Adult Hepatitis B ¹	/ /	/ /			
DTaP/DTP/DT ²	/ /	/ /	/ /	/ /	/ /
Hib ³	/ /	/ /	/ /	/ /	
Pneumococcal (PCV13)	/ /	/ /	/ /	/ /	
Polio	/ /	/ /	/ /	/ /	/ /
Influenza	/ /	/ /			
MMR	/ /	/ /			
Varicella	/ /	/ /	Had Chickenpox or Zoster Disease Yes No		/ /
Hepatitis A	/ /	/ /			
Meningococcal	/ /	/ /			
Td	/ /	/ /			
Tdap	/ /	/ /			
Rotavirus	/ /	/ /	/ /		
HPV	/ /	/ /	/ /		
Men B	/ /	/ /	/ /		
Pneumococcal (PPSV23)	/ /	/ /			

¹Alternative two dose series of approved adult hepatitis B vaccine for adolescents 11 through 15 years of age. ²DTaP, DTP, or DT. ³Hib not required at 5 years of age or more.

- This child is current for immunizations until __/__/__, (14 days after the next shot is due) after which this certificate is no longer valid, and a new certificate must be obtained.
- This child is not up-to-date at this time. This certificate is valid until __/__/__, (14 days after the next shot is due) after which this certificate is no longer valid, and a new certificate must be obtained.

Reason child is not up-to-date:

- Provisional Status** - Child is behind on required immunizations.
- Medical Exemption** - The following immunizations are not medically indicated: _____

If Medical Exemption, can these vaccines be administered at a later date? No: _____ Yes: _____ Date: __/__/__

Religious Objection

I CERTIFY THAT THE ABOVE NAMED CHILD HAS RECEIVED IMMUNIZATIONS AS STIPULATED ABOVE.

(Signature of physician, APRN, PA, pharmacist, LHD administrator, RN or LPN designee)

(Date)

This certificate should be presented to the school or facility in which the child intends to enroll and should be retained by the school or facility and filed with the child's health record.



PREVENTATIVE HEALTH CARE EXAMINATION FORM

All local boards of education shall require a preventative health care examination of each child first entering a Kentucky public school within a period of twelve (12) months prior to initial admission to school and within one (1) year prior to entry to sixth grade. Local school boards may extend this time not to exceed two (2) months. (702 KAR 1:160)

PLEASE COMPLETE THE IDENTIFYING INFORMATION AND RECORDS

IDENTIFYING INFORMATION

Student Name: _____ Gender: M F Grade: _____
 Date of Birth: _____ Age: _____ yrs _____ months Preferred Language: _____
 Parent or Guardian Name: _____

RECORD OF IMMUNIZATIONS TO BE REPORTED ON IMMUNIZATION CERTIFICATE FORM, EPID 230.

MEDICAL HISTORY

Allergies: _____

Current Prescribed Medications to be taken daily at school: _____

Significant Historical Information: _____

SCREENING RESULTS:

Height: _____ ft _____ inches _____ Weight _____ BMI: _____ BMI% _____ B/P: _____

Vision	Right 20/ _____	Passed <input type="checkbox"/>	Hearing - Right	Passed <input type="checkbox"/>	Failed <input type="checkbox"/>	Referred <input type="checkbox"/>
	Left 20/ _____	Failed <input type="checkbox"/>		Passed <input type="checkbox"/>	Failed <input type="checkbox"/>	Referred <input type="checkbox"/>
		Referred <input type="checkbox"/>	Hearing - Left	Passed <input type="checkbox"/>	Failed <input type="checkbox"/>	Referred <input type="checkbox"/>

Optional: Hct/HGB: _____ Lead: _____ Urinalysis: _____

Gross dental (teeth and gums) Normal Abnormal _____ Refer/Tx: _____
 Head/scalp/skin Normal Abnormal _____ Refer/Tx: _____
 Eyes/Ears/Nose/Throat Normal Abnormal _____ Refer/Tx: _____
 Chest/Lungs/Heart Normal Abnormal _____ Refer/Tx: _____
 Abdomen Normal Abnormal _____ Refer/Tx: _____
 Scoliosis assessment Normal Abnormal _____ Refer/Tx: _____

This child has the following problems that may impact the educational experience:

- Vision
 Hearing
 Speech/Language
 Physical
 Social/Behavioral
 Cognitive

Specify: _____

- This child has a health condition that may require emergency action at school, e.g. seizures, allergies. Specify below.

Recommendations (Attach additional sheet if necessary): _____

(Please Check One)

- This child may participate fully in school activities including physical education.
 This child may participate in school activities including physical education with the following restriction/adaptation.

(Specify reason and restriction) _____

ANTICIPATORY GUIDELINES

Discussed and/or handout given

SCHOOL READINESS

- Establish routines
- After-school care/activities
- Friends
- Bullying
- Communicate with teachers

MENTAL HEALTH

- Family time
- Anger management
- Discipline for teaching not punishment
- Limit TV, computer

NUTRITION AND PHYSICAL ACTIVITY

- Healthy weight
- Well-balanced diet, including breakfast
- Fruits, vegetables, whole grains, dairy

- 60 minutes of exercise/day

ORAL HEALTH

- Regular dentist visits
- Brushing/Flossing
- Fluoride

SAFETY

- Sexual safety
- Pedestrian safety
- Safety helmets
- Swimming safety
- Fire escape plan
- Smoke/carbon monoxide detectors
- Guns
- Sun
- Appropriately restrained in all vehicles

Additional comments or recommendations: _____

Signed: _____
Physician/APRN/PA/EPSTDT Provider

Date: _____

Address: _____

Telephone: _____

KRS 156.160 (1) (g) requires proof of a vision examination by an optometrist or ophthalmologist. This evidence shall be submitted to the school no later than January 1 of the first year that a three (3), four (4), five (5) or six (6) year old child is enrolled in public school, public preschool, or Head Start program.

PLEASE COMPLETE THE IDENTIFYING INFORMATION

Date of student's enrollment: _____

Date of Vision Examination: _____

IDENTIFYING INFORMATION

Student Name: _____

Date of Birth: _____

Parent or Guardian Name: _____

CASE HISTORY

Date of Exam: _

Ocular History: Normal or Positive for: _____

Medical History: Normal or Positive for: _____

Drug Allergies: NKDA or Allergic to: _____

Family Ocular and Medical History: Amblyopia Strabismus Glaucoma Diabetes

Other: _

Other Pertinent Information: _

Refraction with cycloplegic? (Please indicate one.) YES NO

	OD	OS
Unaided Acuity	20/	20/
Best Corrected Acuity	20/	20/ <input type="checkbox"/>

Type of Examination	Normal	Abnormal	Notable to Assess
External Exam (eye and adnexa)	<input type="checkbox"/>	<input type="checkbox"/>	
Internal Exam (media, lens, fundus, etc)	<input type="checkbox"/>	<input type="checkbox"/>	
Neurological Integrity (pupils)	<input type="checkbox"/>	<input type="checkbox"/>	
Binocular Function (stereopsis)	<input type="checkbox"/>	<input type="checkbox"/>	
Accommodation and convergence	<input type="checkbox"/>	<input type="checkbox"/>	
Color Vision	<input type="checkbox"/>	<input type="checkbox"/>	

Diagnosis:

Normal Myopia Hyperopia Astigmatism Strabismus Amblyopia

Other: _____

Recommendations: _____

1 Glasses prescribed: YES NO

2 _____

3 _____

Age appropriate and suggested anticipatory guidance (health assessments):

- Educate (parents/patients) about eye/vision disorders and needed vision care
- Counsel (parents/patients) regarding eye safety
- Stress importance of early, preventative eye care
- Recommend re-examination, as appropriate

Signed: _____
Optometrist/Ophthalmologist

Date: _____

Address: _____

Telephone: _____