



COMMONWEALTH OF KENTUCKY
IMMUNIZATION CERTIFICATE

(Required for each child enrolled in day care center, certified family child care home, other licensed facility which cares for children, preschool programs, and public and private primary and secondary schools.)

Name of Child: (Last) (First) (Middle) Birthdate:

Name of Parent of Guardian:

Address: (Street) (City) (State) (Zip code)

DATES IMMUNIZATIONS WERE ADMINISTERED (Month/Day/Year)

Diphtheria, Tetanus, Pertussis* #1 #2 #3 #4 #5

Hib** #1 #2 #3 #4

PCV (Pneumococcal) #1 #2 #3 #4

Polio #1 #2 #3 #4

Hepatitis B*** #1 #2 #3 or Adult dose: #1 #2

MMR (Measles, Mumps, Rubella) #1 #2

Varicella #1 #2 or child has had chickenpox or zoster disease (X)

Tdap #1 or Td #1 Meningococcal #1

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

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child is current for immunizations until __/__/__, (14 days after the next shot is due) after which this certificate is no longer valid, and a new certificate must be obtained.

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

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

(Date)

(Name of Office or Licensed Healthcare Facility)

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: _____

Table with screening results for Vision (Right 20, Left 20) and Hearing (Right, Left). Columns include Passed, Failed, and Referred with checkboxes.

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

- List of physical exam items: Gross dental (teeth and gums), Head/scalp/skin, Eyes/Ears/Nose/Throat, Chest/Lungs/Heart, Abdomen, Scoliosis assessment. Each item has checkboxes for Normal and Abnormal, and a line for 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: _____ Date: _____
 Physician/APRN/PA/EPST Provider

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/

Type of Examination	Normal	Abnormal	Notable to Assess
External Exam (eye and adnexa)			
Internal Exam (media, lens, fundus, etc)			
Neurological Integrity (pupils)			
Binocular Function (stereopsis)			
Accommodation and convergence			
Color Vision			

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: () _____