

**Middlebury Community Schools  
Health Services  
Immunization/Birth Certificate Letter for All Kindergarten  
And Newly Enrolled First Grade Students**

Dear Parent/Guardian:

Indiana Law\* requires that the student produce a legal **BIRTH CERTIFICATE** within 14 days after enrollment. If after 30 days the student has not produced a birth certificate, they must be reported to the Department for Missing Children. You can obtain this from the Vital Records office @ the Health Department from the county of Birth if you do not already have this.

Indiana Law requires **COMPLETED IMMUNIZATIONS** or a planned schedule for completion for ALL school children. The record must show the month, day, and year the immunizations were given. This record may be mailed to or dropped off at the school as soon as it is complete. An immunization record must be on file at the school **no later than the first day of school**. After that date your child will be unable to attend school.

KINDERGARTEN AND GRADE 1  
5 DPT (Diphtheria, Pertussis, Tetanus)  
4 TOPV (Oral and/or Injectable)  
1 MMR (Measles, Mumps, Rubella)  
2<sup>nd</sup> Measles or MMR  
3 Hepatitis B  
1 Varicella (Chicken Pox) or record of Disease

If you have **an objection to immunizations for religious or medical reasons**, a written and signed statement must be presented to the school before the first day of school, and a new one must be filled out and signed each school year. (Forms are available at the school office.)

Thank you for your cooperation,

The School Nurses

MIDDLEBURY COMMUNITY SCHOOLS

Health Services

Name \_\_\_\_\_ Birth Date \_\_\_\_\_

Month/day/year

Parent or Guardian \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_ Date \_\_\_\_\_

This form must be back by the first day of school.

DOCTOR'S EXAMINATION

Eyes \_\_\_\_\_ Ears \_\_\_\_\_

Visual Acuity L \_\_\_\_\_ R \_\_\_\_\_ Hearing (gross) \_\_\_\_\_

Wears Glasses \_\_\_\_\_

Referred to eye specialist \_\_\_\_\_

Weight \_\_\_\_\_ Urinalysis \_\_\_\_\_

Height \_\_\_\_\_ Hemoglobin \_\_\_\_\_

Blood Pressure \_\_\_\_\_ or Hematocrit \_\_\_\_\_

Nose \_\_\_\_\_ Abdomen \_\_\_\_\_

Throat \_\_\_\_\_ Hernia \_\_\_\_\_

Lungs \_\_\_\_\_ Genitalia \_\_\_\_\_

Skin \_\_\_\_\_ Orthopedic \_\_\_\_\_

Lymph Glands \_\_\_\_\_ Allergies \_\_\_\_\_

(If student has insect sting allergies, please indicate appropriate treatment.) \_\_\_\_\_

Physically fit to participate in physical education program? Yes \_\_\_\_\_ No \_\_\_\_\_

Competitive sports? Yes \_\_\_\_\_ No \_\_\_\_\_

Restriction? \_\_\_\_\_ Please explain \_\_\_\_\_

Date of Examination \_\_\_\_\_

Phone \_\_\_\_\_

\_\_\_\_\_  
Physician's Signature

**IMMUNIZATIONS: (To be filled out by: parent, using student's personal health records, or Doctor's office, may send a copy of their records or list the month, day and year for each)**

	# 1	# 2	# 3	# 4	# 5	# 6
	mo/day/yr	mo/day/yr	mo/day/yr	mo/day/yr	mo/day/yr	mo/day/yr
DPT						
Td						
IPV, OPV which one						
Hep.B						
H.I.B.						
*Chicken Pox						
M.M.R.						
Measles						
Rubella						
Mumps						

\*Had Chicken Pox \_\_\_\_\_ (date)

H-1  
Kindergarten  
03/2009

MIDDLEBURY COMMUNITY SCHOOLS  
57853 Northridge Drive  
Middlebury, Indiana 46540

H-9

SPECIAL HEALTH CONDITION FORM

School Year \_\_\_\_\_

Student's Name: \_\_\_\_\_ Grade: \_\_\_\_\_

Parent's Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Mother's Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Father's Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Address: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Dentist's Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Dear Parent,

Your child's health and safety is very important to us. We feel it is very important that each school have current information about students with health problems. In order to do this, we will need the following information:

1. MY CHILD HAS:	BRIEF EXPLANATION:
ASTHMA Inhaler or Nebulizer	_____
DIABETES Is there a family history of diabetes?	_____
SEIZURES Last one, triggers?	_____
ALLERGIES (include foods, bee stings, Medicines, etc.) Was an Epi-Pen prescribed?	_____
HEART DISEASE/PROBLEMS	_____
CANCER/LEUKEMIA	_____
PHYSICAL DISABILITIES	_____
OTHER	_____
_____	_____
_____	_____

2. DOES YOUR CHILD TAKE MEDICATION REGULARLY?	LIST:
Home	_____
During School Hours	_____

3. MY CHILD HAS HAD: DATE AND BRIEF EXPLANATION:  
CHICKENPOX  
BROKEN BONES  
SURGERY

4. PLEASE SHARE ANY ADDITIONAL INFORMATION YOU FEEL WE SHOULD KNOW ABOUT YOUR CHILD:

5. DID YOUR CHILD HAVE ANY IMMUNIZATIONS OVER THE SUMMER? \_\_\_\_\_  
LIST: \_\_\_\_\_

6. In case of emergency, parents will be called first. If the school is unable to reach a parent, please list two emergency contact numbers:

EMERGENCY Contact Person #1 \_\_\_\_\_ Phone: \_\_\_\_\_

EMERGENCY Contact Person #2 \_\_\_\_\_ Phone: \_\_\_\_\_

7. Many qualified school employees work with your child. We feel it is very important that all school employees, including bus drivers, cooks, substitute teachers etc., know when students have special health concerns that need immediate attention. Please assist us in meeting your child's needs by signing below.

In order that my child may receive the best possible health care, I give permission for the information on this form to be shared with necessary school employees.

\_\_\_\_\_  
Parent's Signature

\_\_\_\_\_  
Date