ZION LUTHERAN SCHOOL
Seymour, IN 47274

Dear Parent and/or Guardians,

We hope that you find your child's Kindergarten year an exciting one.

If your child has any special needs that need to be addressed at school, please let us know. I will be happy to meet with you if you have any questions or concerns related to your child's health.

If you would like to meet with the school nurse, please fill out the form below and return it to the school office.

Please have your medical providers complete the attached examination forms concerning your Kindergarten child. **These completed forms, along with a copy of your child's birth certificate, must be turned into the ZLS school office by the first day of school.**

Thank you,
Zion Lutheran School
Principal

I would like to meet with the Principal, concerning issues with my child's health.

YES_____ NO_____

Child's Name _____

Parent's Name _____

Phone Number _____

Comments:_____

_____

_____

ZION LUTHERAN SCHOOL

Health Examination Form

Child's Name _____ Exam Date:_____

Date of Birth _____

School child will be attending: Zion Lutheran School

Allergies: _____

Will an Epi Pen be needed at school: _____

PHYSICAL EXAMINATION (code: No Defect 0 Defect – Note)

Immunizations

DTP/DT/TD 1._____
DtaP 2._____
3._____
4._____
5._____
6._____

Polio 1._____
2._____
3._____
4._____
5._____

MMR 1._____
2._____

HBV 1._____
2._____
3._____

Varicella 1._____
2._____

Chickenpox Disease _____YES
_____NO
Date: _____

Hep A 1._____
2._____

Height _____
Weight _____
Head _____
Eyes _____
Ears _____
Nose _____
Throat _____
Heart _____
B/P _____
Lungs _____
Abdomen _____
Posture _____
Operations _____
_____

Serious Illness/Injuries

_____
_____

Is there any condition which should be considered in planning this child's school program?

_____
_____
_____

_____
MD signature

ZION LUTHERAN SCHOOL

Dental Examination Form

Child's Name _____ Date:_____

Date of Birth _____

School child will be attending: Zion Lutheran School

DENTAL EXAMINATION

(code: No Defect 0 Defect – Note)

TEETH:

Cavities _____

Malocclusions _____

PRESENT STATUS:

Restorations _____

_____

APPOINTMENTS SCHEDULED: _____

RECOMMENDATIONS: _____

_____

Date of Exam: _____

_____

DDS Signature

ZION LUTHERAN SCHOOL

Eye Examination Form

Child's Name _____ Date:_____

Date of Birth _____

School child will be attending: Zion Lutheran School

STUDENT VISION REPORT

1. Visual Acuity — Pass — Fail

		Distance		Near	
Undecided	R. eye 20/	L. eye 20/	R. eye 20/	L. eye 20/
Corrected	R. eye 20/	L. eye 20/	R. eye 20/	L. eye 20/

   Remarks: _____

2. Refractive Error — Pass — Fail
   Remarks: _____
3. Ocular Health — Pass — Fail
   Remarks: _____
4. Eye Muscle Balance — Pass — Fail
   Remarks: _____
5. Binocular Depth Perception — Pass — Fail
   Remarks: _____
6. Accommodation (Focusing Ability) — Pass — Fail
   Remarks: _____
7. Color Perception — Pass — Fail
   Remarks: _____
8. Other Remarks: _____

*Analysis of Vision and Eye Health _____

Recommendations _____

No Treatment Indicated _____

Glasses/Contacts _____

Prescribed _____

Present Prescription Satisfactory _____

Vision Therapy _____

Other_____

OVER

Purpose of Glasses/Contact Lenses (if prescribed) _____
Should be worn: (a) Constant wear (b) Desk Work Only (c) Far Vision Only

Recommendations for Classroom Teacher _____

Re-examination advised in _____

I, being licensed to practice optometry and/or ophthalmology, certify that this child's vision and eye health have been examined by me and:

Are sufficient to enter Kindergarten _____

Or

Appropriate treatment has been recommended for deficiencies in this child's vision or eye health _____

Date _____ Signed _____