

Rush County Schools
Report of Health Examination

NAME _____ DATE of BIRTH _____

SCHOOL _____

Minimum Immunization Requirements for Kindergarten

- ❖ 5 doses of diphtheria-tetanus-acellular pertussis (**DTaP**), diphtheria-tetanus-pertussis (**DTP**) (*4 doses are acceptable if the fourth dose was administered on or after the fourth birthday.*)
- ❖ 4 doses of either oral polio vaccine (**OPV**) or inactivated polio vaccine (**IPV**) in any combination (*4th dose must be administered on or after 4th birthday*), or 3 doses of **ALL OPV** or **ALL IPV** are acceptable *if* the third dose was administered on or after the fourth birthday.
- ❖ 2 doses of mumps, measles, and rubella (**MMR**) vaccine, on or after the first birthday
- ❖ 3 doses of hepatitis B vaccine
- ❖ 2 doses Hepatitis A
- ❖ 2 dose of **varicella** (chickenpox) or statement from your physician that your child has had the disease including the date.
- ❖ Physical Exam
- ❖ Dental Exam

A Legal Birth Certificate is required for ALL students

To Be Completed by Your Health Care Provider

HEIGHT _____	WEIGHT _____	THROAT _____
NUTRITION _____		GLANDS _____
ORTHOPEDIC _____		THYROID _____
FEET _____		HEART _____
POSTURE _____		LUNGS _____
SKIN & SCALP _____		VISION R _____ L _____
EYES _____		HEARING _____
EARS _____		NERVOUS SYSTEM _____
NOSE _____		SPEECH DEFECT _____
REMARKS AND/OR RECOMMENDATIONS _____		

CHRONIC HEALTH ISSUES _____

SIGNIFICANT INFORMATION SCHOOL SHOULD KNOW _____

EXAMING HEALTH CARE PROVIDER (PRINTED NAME) _____

SIGNATURE _____ DATE _____

To be Completed by your Dentist

This is to verify that I have examined the teeth and mouth of: _____ and:

_____ All Necessary Dental Work Has Been Completed

_____ Treatment in Progress

_____ Needs Dental Work-Not Scheduled at this Time

_____ Is in Need of NO Dental Work At This Time

Comments/Concerns: _____

EXAMING DENTIST (PRINTED NAME) _____

SIGNATURE: _____ DATE: _____