SAINT JOSEPH
HEALTH SYSTEM
A Member of Trinity Health

Dear Parents and Guardians,

The enclosed packet of information will need to be completed and returned by the first day of school. The law in the State of Indiana requires that your child have certain immunizations in order to attend school. **Please make sure that the immunization information is read carefully as the Indiana State Department of Health and the Indiana Department of Education have made mandatory requirements by grade level for the 2021-2022 school year.** Below is the minimum number of immunizations required according to grade level:

- Pre-school-Pre-Kindergarten: 4 DTaP, 3 Polio, 3 Hepatitis B, 1 MMR, 2 Hepatitis A, and 1 Varicella, or physician written documentation of history of disease, including month and year
- Kindergarten – Fifth Grade: 5 DTaP, 4 Polio, 3 Hepatitis B, 2 Hepatitis A, 2 MMR, and 2 Varicella, or physician written documentation of history of disease, including month and year
- Sixth – Eighth Grades: 5 DTaP, 4 Polio, 3 Hepatitis B, 2 Hepatitis A, 2 MMR, 1 Meningococcal, 1 Tdap, and 2 Varicella, or physician written documentation of history of disease, including month and year.

Once your child is accepted at school, please send in the forms found in this packet. We will accept exams that were completed within the last twelve months. **Please make sure there is a physician generated copy of immunizations included with the forms sent to school.** The State of Indiana only recognizes objection to immunizations for medical and religious reasons. There is a form that must be completed annually and on file by the first day of each school year. Please note, a physician is the only health care provider who can sign for a medical objection. Only a parent need to complete the religious objection. You may send in or fax all health documents to the school as well.

Sincerely yours,

Beth Kirk, RN, BSN Maureen VerVaet, RN, BSN

Medical Centers

Mishawaka Medical Center
5215 Holy Cross Pkwy.
Mishawaka, IN 46545
574.335.5000

Plymouth Medical Center
1915 Lake Ave.
Plymouth, IN 46563
574.948.4000

Senior Services

Holy Cross
17475 Dugdale Dr.
South Bend, IN 46635
574.247.7500

Saint Joseph PACE
250 E. Day Rd.
Mishawaka, IN 46545
574.247.8700

St. Paul's
3602 S. Ironwood Dr.
South Bend, IN 46614
574.284.9000

Trinity Tower
316 S. Dr. Martin Luther King Jr. Blvd.
South Bend, IN 46601
574.335.1900

VNA Home Care
3838 N. Main St., Ste. 100
Mishawaka, IN 46545
574.335.8600

Community-Based Programs

The Foundation
707 E. Cedar St., Ste. 100
South Bend, IN 46617
574.335.4540

Health Insurance Services
5215 Holy Cross Pkwy.
Mishawaka, IN 46545
1.855.88.SJMED (1.855.887.5633)

Community Health & Well-Being
707 E. Cedar St., Ste. 100
South Bend, IN 46617
574.335.4685

Physician Network
707 E. Cedar St., Ste. 220
South Bend, IN 46617
574.335.8758

Physician Certificate of Examination Form

(To be completed by a physician/healthcare provider)
Please Print!

◯ ***IMMUNIZATION DOCUMENTATION ATTACHED***

Name: _____ Date of Birth: ____/____/____

Allergies: _____ ◯ Epi Pen Needed

Current Medications: (List name, dosage, and time):

1. _____ Dosage: _____ Time: _____
2. _____ Dosage: _____ Time: _____

Height: _____ Weight: _____ B/P: _____
Eyes: _____
Ears: _____ Lead Level (if indicated): _____
Nose: _____
Throat: _____ Sickle Cell (If indicated): _____
Chest: _____
Heart: _____ TB Test: (Recommended)
Hernia: _____ Date Given: _____
Extremities: _____ Date Read: _____
Posture/Scoliosis: _____ Results: _____

- **Does this child have any health condition that would be hazardous either to the child or to the other children in the group setting as a result of participation in normal activities (including sports)** ◯ YES ◯ NO
- If Yes, what modification of normal activities would be necessary to protect the child and the child's classmates _____

Physician/Healthcare Provider Completing this Form: _____
Please Print/Stamp
Physician/Healthcare Provider's Signature: _____ Date: _____

Certificate of Dental Examination

Teeth:

1. Cavities: _____
2. Soft Tissue: _____
3. Oral Hygiene: _____

Present Status:

- Does the patient presently have any tooth decay or other dental defects which may reduce his/her efficiency or prevent him/her from receiving the full benefit of his/her school work?
  - If yes, please explain: _____

Recommendations: _____
Dentist's Name (Stamp or Print): _____
Dentist's Signature: _____ Date: _____

Health Questionnaire

(Parent/Guardian needs to complete)

Please Print!

Student:_____ Date of Birth:____/____/____

Address: _____

City: _____ Zip: _____ Phone Number:_____

School: _____ Entering Grade: _____

Father's Name: _____ Mother's Name: _____

Student Lives With: _____

Disease/Condition	Yes (List month/year)	No	Disease/Condition	Yes (List month/year)	No
Asthma			Mumps		
Diabetes			Rheumatic Fever		
Seizures			Rubella		
Chickenpox			Measles		
Food Allergy			Other		

Has your child had an infections/communicable disease other than those listed above? Please explain giving relevant dates: _____

Please list any of the following with the month/year:

- Operations: _____
- Illnesses (Eye, ear, heart, stomach, kidney): _____
- Severe Injuries (Head injury, fractures, etc.): _____

Is there any other information about your child's health status that you think the school should know which may be relevant to your child's health and safety or the health and safety of others in the school environment? _____

Please list any condition that should be considered in planning your child's school day:

_____

Allergies/Reactions: _____

◯ Allergy Care Plan Needed ◯ Epi Pen Needed ◯ Diabetic Care Plan Needed

Physician Name: _____ Phone #: _____

Dentist Name: _____ Phone #: _____

To the best of my knowledge the above information is complete and accurate. I acknowledge that I have a continuing obligation to inform the school of any changes in my child's health status that are relevant to the information requested by this form.

Parent Signature: _____ Date: _____

Student's Name: _____ # of Times Sent Home: _____ Grade: _____

Diocese of Fort Wayne-South Bend Schools

Dear Parent/Guardian,

The Indiana State Department of Health maintains an immunization registry entitled CHIRP. CHIRP allows all health care providers within the state of Indiana to enter immunization data as a method of electronic documentation. CHIRP ensures that the most up-to-date record of immunizations is available to all health care providers. The Indiana Department of Education mandated that all schools within the state of Indiana utilize CHIRP to document annual immunization reports. Schools are required to submit these immunization reports to maintain the schools' accreditation. The school is requesting your permission to submit the immunization status of your child using this format. Please make a copy of this consent for each of your student's.

I _____, give the Diocese of Fort Wayne/South Bend Schools, permission to release the following information concerning my child _____

To the Indiana State Department of Health's: Children and Hoosiers Immunization Registry Program (CHIRP):

Student's full name, date of birth, immunization data, and demographic data such as address, telephone number, and the school in attendance.

I understand that the information in the registry may be used to verify that my child has received proper immunizations and to inform me if my child's immunization status or that an immuzation is due according to the recommended immunization schedules.

I understand that my child's information may be available to the immunization data registry of another state, a healthcare provider or a provider's designee, a local health department, an elementary or secondary school, a child care center, the office Medicaid policy and planning or a contractor of the office of Medicaid policy planning, a licensed child placing agency, and a college or university. I also understand that other entities may be added to this list through amendment to I.C. 16-38-5-3.

_____ _____

Signature of Parent/Guardian Date

_____ _____

Printed Name of Parent/Guardian Grade Level

_____

Complete Address City Zip

_____ _____

Child's Name School

PLEASE RETURN THIS FORM BY THE FIRST DAY OF SCHOOL!

Written Consent for Administration of Medication

Parent/Guardian

In order to protect the health and welfare of the students and school staff alike, Indiana laws requires that parent's consent, in writing, to the administration of medication. In order for the school nurse, volunteer school nurse, or a staff member to administer medication to your student the form below must be read and signed.

1. The school **must have on record a written order from the prescribing physician/practitioner and written consent from the parent/guardian for prescription medication**. There must be a written request from the parent/guardian for Over the Counter (OTC) medications before they will be administered to a student at school.
2. **Medications prescribed and/or OTC meds should be kept in the original container with the pharmacy or brand label affixed. The label must include the following**:
   - Student's Name
   - Name of Medication
   - Dosage of Medication
   - Prescribing Physician/Practitioner (if applicable)
3. **Medication brought to the school must be checked in at the office and kept in a locked cabinet.**
4. **PRESCHOOL, ELEMENTARY, AND JUNIOR HIGH STUDENTS MAY NOT TRANSPORT MEDICATIONS TO SCHOOL AT ALL. *MEDICATIONS MUST BE BROUGHT TO SCHOOL AND PICKED UP BY AN ADULT.***
5. The school nurse/assigned staff member must be aware of the purpose for which the student is receiving the medication.
6. In specific cases, the school nurse/assigned staff member may require the parent(s)/guardian to come to the school to administer the medication.
7. All prescribed medication will be administered strictly in accordance with the written order of the physician/practitioner. The dosage may be changed only if the school is provided with the written order of the physician/practitioner authorizing the change. The school secretary/staff can not take a physician order over the phone.
8. Over-the-counter medication will not be administered in any manner inconsistent with the instructions on the brand label, unless the school receives a written order of a physician/practitioner authorizing such administration.

I have read and understand the above policy.

_____Please administer to my child, _____, the prescribed medication(s) written below, in accordance with the written order of the physician/practitioner.

AND/OR

_____Please administer to my child, _____, the over-the-counter medication(s) as described below:

Medication	Dosage (Mg and # of tabs)	Time	Precautions/side effects
1.			
2.			
3.			
4.			

- Period of time medication is to be continued:_____
- Reason for medication:_____

Parent/Guardian Signature: _____Date_____
Printed Name: _____ Phone #:_____

Written Consent for Administration of Medication

Physician/Health Care Provider

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- Reason for medication:_____

Physician Signature: _____Date_____
Printed Name: _____ Phone #:_____