LEARNING TO LEAD AND SERVE AS SAINTS
SAINT JOSEPH
CATHOLIC SCHOOL

Consent to Release Information to CHIRP

(Children and Hoosier Immunization Registry Program)

2211 Brooklyn Avenue • Fort Wayne, IN 46802
Phone 260.432.4000 • Fax 260.432.8642

Parent Name: _____

Parent Signature: _____

Date: _____

The Indiana State Department of Health is requesting that school districts report immunization rates by sharing individual immunization information. In order to share your child's information we need your consent. Please complete this consent form and return it to your school with other registration materials.

I give St. Joseph Catholic School permission to release the following information concerning my child to the Indiana State Department of Health's CHIRP: *Child's name, date of birth, immunizations, parent/legal guardian's name and other identifying information as applicable.*

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

I understand that my child's information will be available to the immunization data registry of another state, a healthcare provider, a local health department, an elementary or secondary school that is attended by the individual, a childcare center, and the office of Medicaid policy and planning or a contractor of the office of Medicaid policy and planning. I also understand that other entities may be added to this list through amendment to I.C. 16-38-5-3. I hereby consent to the release of such information.

:

_____ _____

Child's First, Middle, and Last Name (Print) Parents/Legal Guardian's Signature

Date of Birth: _____ Date_____

~ Learning to Lead and Serve as Saints ~

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			Scarlet Fever		
Measles			Other		

Has your child had an infectious/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 Injures (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: _____

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 _____

Certificate of Dental Examination

Please Print

Student's Name_____

Parent/Guardian Name_____

School_____

This form is to completed by your dentist.

Dental Examination

Code: No Defect = 0 Defect = Note Condition

1. **Teeth**

    1. Cavities_____
    2. Malocclusion

    _____

    3. Soft Tissue

    _____

    4. Oral Hygiene

    _____

2. **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 _____
3. **Recommendations:** _____

_____ _____

Print/Stamp Dentist's Name Date

_____

Signature

SWM 2016

Physician Certificate of Examination Form

(To be completed by a physician)

Please Print!

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

Allergies_____

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: _____ **P.P.D.: (Recommended)**

Hernia: _____ Date Given:_____

Extremities: _____ Date Read:_____

Posture/Scoliosis: _____ Results:_____

- Physically fit to participate in all physical education programs? Yes No
  If "No" please explain:_____
- Please list any condition that should be considered in planning this child's school day:_____

Immunization Record: (Month/Day/Year)

DtaP/Tdap:

1._____

2._____

3._____

4._____

5._____

IPV (please indicate if OPV)

1._____

2._____

3._____

4._____

Hepatitis B:

1._____

2._____

3._____

M.M.R:

1._____

2._____

Varicella:

1._____

2._____

Date of Chicken Pox Disease:_____

Hepatitis A:

1._____

2._____

Pertussis:

1._____

Menactra:

1._____

HPV:

1._____

2._____

3._____

Physician Completing this form: _____

Please Print/Stamp

Physician's Signature:_____Date_____