

HOME LANGUAGE SURVEY

Student Name: _____ Birth Date: _____ Sex: Male Female

Parent/Guardian Name: _____

Address: _____

Home Telephone: _____ Work Telephone: _____

School: _____ Grade: _____ Date: _____

1. Was your child born in the United States? Yes No

If yes, in which state? _____

If no, in what other country? _____

2. Has your child attended any school in the United States for any three years during their lifetime? Yes No

If yes, please provide school name(s), state, and dates attended:

Name of School _____ State _____ Dates Attended _____

Name of School _____ State _____ Dates Attended _____

Name of School _____ State _____ Dates Attended _____

3. What language is spoken by you and your family most of the time at home? _____

4. If available, in what language would you prefer to receive communication from the school? _____

5. Is your child's first-learned or home language anything other than English? Yes No

If you responded "Yes" to question number 5 above, please answer the following questions:

6. What language did your child learn when he/she first began to talk? _____

7. What language does your child most frequently speak at home? _____

8. What language do you most frequently speak to your child? (Father) _____

(Mother) _____

9. Please describe the language understood by your child. (Check only one)

A. Understands only the home language and no English.

B. Understands mostly the home language and some English.

C. Understands the home language and English equally.

D. Understands mostly English and some of the home language.

E. Understands only English.

Parent or Guardian's Signature

Date

OFFICE USE ONLY

Student ID #	Date Distributed	Date Received	

Student Race and Ethnicity Reporting

Student Name: _____ Date Form Completed: _____

Date of Birth: _____ Male Female

Person Completing This Form: Parent/Guardian Student Other: _____

The U.S. Department of Education has implemented new standards for school districts to report student race and ethnicity. Your answers to the following will be held strictly confidential and data will be used only in the aggregate.

1. Is your child of Hispanic, Latino, or Spanish ethnicity: Yes No
Includes persons of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin.

If you answered "Yes" to question #1, you may also check one or more of the racial categories in question #2. If you answered "No", please check one or more of the following racial categories.

2. Racial Categories:

- American Indian or Alaska Native
Origins in any of the original peoples of North, Central, and South America who maintain a tribal affiliation or community attachment.
- Asian
Origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent for example Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, Philippine Islands, Thailand, and Vietnam.
- Black or African American
Origins in any of the black racial groups of Africa
- Native Hawaiian or Other Pacific Islander
Origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
- White
Origins in any of the original peoples of Europe, the Middle East, or North Africa.

Please complete the entire form and return it to:

Name: _____ Phone Number: _____

Address: _____ City: _____ State: _____ Zip: _____

**Iowa Department of Public Health
 CERTIFICATE OF VISION SCREENING
 RETURN COMPLETED FORM TO CHILD'S SCHOOL.**

Student Information (please print)

Student Last Name:	Student First Name:	Birth Date (M/D/YYYY):
Parent/Guardian Telephone Number:	Student Address:	
Zip Code:		

Screening Information (vision screening provider must complete this section *or parents may attach a copy of vision screening results given to them by a provider.*)

Date of Vision Screening: _____	
Results (visual acuity):	
Right Eye _____	Left Eye _____
Overall Result (Please select one):	Referral to eye health professional (Please select one):
Pass or Fail	Yes or No

Screening Provider: _____

Provider Business Name/Source of Screening: (please print) _____

Provider Name: (please print) _____ Phone: _____

Signature and Credentials of Provider: _____ Date: _____

A parent or guardian of a child who is to be enrolled in a public or accredited nonpublic elementary school shall ensure the child is screened for vision impairment at least once before enrollment in Kindergarten **and** again before enrollment in the 3rd grade.

To be valid, a minimum of one child vision screening shall be performed no earlier than one year prior to the date of enrollment in Kindergarten and no later than six months after the date of the child's enrollment in Kindergarten.

To be valid, a minimum of one child vision screening shall be performed no earlier than one year prior to the date of enrollment in 3rd grade and no later than six months after the date of the child's enrollment in 3rd grade.

RETURN COMPLETED FORM TO CHILD'S SCHOOL.



Iowa Department of Public Health Child Vision Screening

1. Parents or guardians need to make sure their child has a vision screening at least once before starting kindergarten and again before starting 3rd Grade.
2. Kindergarten Screenings: A screening will be counted if it is done no earlier than 1 year before and no later than 6 months after school starts.
3. 3rd Grade Screenings: A screening will be counted if it is done no earlier than 1 year before and no later than 6 months after school starts.
4. The requirement for a child vision screening will count by any of the following:
 - a. A vision screening or comprehensive eye exam by an eye doctor (ophthalmologist or optometrist).
 - b. A vision screening conducted at a doctor's office, a free clinic, a child care center, a local public health department, a public or accredited nonpublic school, or a community-based organization or by an advanced registered nurse practitioner or physician assistant.
 - c. A vision screening done by Prevent Blindness Iowa volunteers or Iowa KidSight and Lion's Club Volunteers.
5. The child vision screening requirement does not apply if the child vision screening conflicts with a parent's or guardian's genuine and sincere religious belief.
6. A child will not be withheld from school because a parent or guardian did not provide proof that the child received a vision screening.

***Please direct questions regarding vision screening to:
Iowa Department of Public Health - Bureau of Family Health
321 E 12th Street - Des Moines, IA 50319
FAX 515-725-1760 - Phone 800-383-3826***



Iowa Department of Public Health CERTIFICATE OF DENTAL SCREENING

**This certificate is not valid unless all fields are complete.
RETURN COMPLETED FORM TO CHILD'S SCHOOL.**

Student Information (please print)

Student Last Name:	Student First Name:	Birth Date (M/D/YYYY):
Parent or Guardian Name:		Telephone (home or mobile):
Street Address:	City:	County:
Name of Elementary or High School:	Grade Level:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female

Screening Information (health care provider must complete this section)

Date of Dental Screening: _____

Treatment Needs (check ONE only based on screening results, prior to treatment services provided):

- No Obvious Problems** – the child’s hard and soft tissues appear to be visually healthy and there is no apparent reason for the child to be seen before the next routine dental checkup.
- Requires Dental Care** – tooth decay¹ or a white spot lesion² is suspected in one or more teeth, or gum infection³ is suspected.
- Requires Urgent Dental Care** – obvious tooth decay¹ is present in one or more teeth, there is evidence of injury or severe infection, or the child is experiencing pain.

¹ Tooth decay: A visible cavity or hole in a tooth with brown or black coloration, or a retained root.
² White spot lesion: A demineralized area of a tooth, usually appearing as a chalky, white spot or white line near the gumline. A white spot lesion is considered an early indicator of tooth decay, especially in primary (baby) teeth.
³ Gum infection: Gum (gingival) tissue is red, bleeding, or swollen.

Screening Provider (check ONE only):

DDS/DMD RDH MD/DO PA RN/ARNP (High school screen must be provided by DDS/DMD or RDH)

Provider Name: (please print) _____ Phone: _____

Provider Business Address: _____

Signature and Credentials of Provider or Recorder*: _____ Date: _____

*Recorder: An authorized provider (DDS/DMD, RDH, MD/DO, PA, or RN/ARNP) may transfer information onto this form from another health document. The other health document should be attached to this form.

A screening does not replace an exam by a dentist.
Children should have a complete examination by a dentist at least once a year.

RETURN COMPLETED FORM TO CHILD'S SCHOOL.



Iowa Department of Public Health Certificate of Immunization

Name Last: _____ First: _____ Middle: _____ Date of Birth: _____

Parent/Guardian: _____ Address: _____ Phone: _____

I certify that the above named applicant has a record of age-appropriate immunizations that meet the requirement for licensed child care or school enrollment.

Signature: _____ Date: _____

Physician, Physician Assistant, Nurse, or Certified Medical Assistant

A representative of the local Board of Health or Iowa Department of Public Health may review this certificate for survey purposes.

Diphtheria, Tetanus, Pertussis DTaP/DTP/DT/ Td/Tdap	Vaccine	Date Given	Doctor / Clinic / Source

Polio IPV/OPV	Vaccine	Date Given	Doctor / Clinic / Source

Measles, Mumps, Rubella MMR	Vaccine	Date Given	Doctor / Clinic / Source

Haemophilus influenzae type b Hib	Vaccine	Date Given	Doctor / Clinic / Source

Hepatitis B	Vaccine	Date Given	Doctor / Clinic / Source

Varicella Chicken Pox	Vaccine	Date Given	Doctor / Clinic / Source

If applicant has a history of natural disease write "Immune to Varicella"

Pneumococcal PCV/PPSV	Vaccine	Date Given	Doctor / Clinic / Source

Meningococcal MCV/MPSV/ Mening B	Vaccine	Date Given	Doctor / Clinic / Source

Hepatitis A	Vaccine	Date Given	Doctor / Clinic / Source

Rotavirus	Vaccine	Date Given	Doctor / Clinic / Source

Human Papilloma Virus HPV	Vaccine	Date Given	Doctor / Clinic / Source

Other	Vaccine	Date Given	Doctor / Clinic / Source

IMMUNIZATION REQUIREMENTS

Applicants enrolled or attempting to enroll shall have received the following vaccines in accordance with the doses and age requirements listed below. If, at any time, the age of the child is between the listed ages, the child must have received the number of doses in the "Total Doses Required" column.

Institution	Age	Vaccine	Total Doses Required	
Licensed Child Care Center	19 months through 23 months of age	This is not a recommended administration schedule, but contains the minimum requirements for participation in licensed child care. Routine vaccination begins at 2 months of age.		
			Diphtheria/Tetanus/Pertussis	1 dose
			Polio	1 dose
			<i>haemophilus influenzae</i> type B	1 dose
			Pneumococcal	1 dose
			Diphtheria/Tetanus/Pertussis	2 doses
			Polio	2 doses
			<i>haemophilus influenzae</i> type B	2 doses
			Pneumococcal	2 doses
			Diphtheria/Tetanus/Pertussis	3 doses
			Polio	2 doses
			<i>haemophilus influenzae</i> type B	2 doses if the applicant received 1 dose before 15 months of age; or 1 dose if received when the applicant is 15 months of age or older.
			Pneumococcal	3 doses if the applicant received 1 or 2 doses before 12 months of age; or 2 doses if the applicant has not received any previous doses or has received 1 dose on or after 12 months of age.
			Diphtheria/Tetanus/Pertussis	4 doses
Polio	3 doses			
Elementary or Secondary School (K-12)	4 years of age and older	This is not a recommended administration schedule, but contains the minimum requirements for participation in licensed child care. Routine vaccination begins at 2 months of age.		
			Diphtheria/Tetanus/Pertussis	1 dose
			Polio	1 dose
			<i>haemophilus influenzae</i> type B	1 dose
			Pneumococcal	1 dose
			Diphtheria/Tetanus/Pertussis	2 doses
			Polio	2 doses
			<i>haemophilus influenzae</i> type B	2 doses
			Pneumococcal	2 doses
			Diphtheria/Tetanus/Pertussis	3 doses
			Polio	2 doses
			<i>haemophilus influenzae</i> type B	2 doses if the applicant received 1 dose before 15 months of age; or 1 dose if received when the applicant is 15 months of age or older.
			Pneumococcal	4 doses if the applicant received 3 doses before 12 months of age; or 3 doses if the applicant received 1 or 2 doses before 12 months of age; or 2 doses if the applicant has not received any previous doses or has received 1 dose on or after 12 months of age.
			Measles/Rubella ¹	1 dose of measles/rubella-containing vaccine received on or after 12 months of age; or the applicant demonstrates a positive antibody test for measles and rubella from a U.S. laboratory.
Varicella	1 dose received on or after 12 months of age, unless the applicant has a reliable history of natural disease.			
Diphtheria/Tetanus/Pertussis	4 doses			
Polio	3 doses			
<i>haemophilus influenzae</i> type B	3 doses, with the final dose in the series received on or after 12 months of age; or 2 doses if only 1 dose received before 15 months of age; or 1 dose if received when the applicant is 15 months of age or older.			
Pneumococcal	Hib vaccine is not required for persons 60 months of age or older. 4 doses if the applicant received 3 doses before 12 months of age; or 3 doses if the applicant received 2 doses before 24 months of age; or 2 doses if the applicant received 1 dose before 24 months of age; or 1 dose if the applicant did not receive any doses before 24 months of age. Pneumococcal vaccine is not required for persons 60 months of age or older.			
Measles/Rubella ¹	1 dose of measles/rubella-containing vaccine received on or after 12 months of age; or the applicant demonstrates a positive antibody test for measles and rubella from a U.S. laboratory.			
Varicella	1 dose received on or after 12 months of age, unless the applicant has had a reliable history of natural disease.			
Diphtheria/Tetanus/Pertussis	3 doses, with at least 1 dose of diphtheria/tetanus/pertussis-containing vaccine received on or after 4 years of age if the applicant was born on or before September 15, 2000 ² ; or 4 doses, with at least 1 dose of diphtheria/tetanus/pertussis-containing vaccine received on or after 4 years of age if the applicant was born after September 15, 2000, but on or before September 15, 2003 ² ; or 5 doses with at least 1 dose of diphtheria/tetanus/pertussis-containing vaccine received on or after 4 years of age if the applicant was born after September 15, 2003 ² ; and 1 time dose of tetanus/diphtheria/acellular pertussis-containing vaccine (Tdap) for the applicant in grades 7 and above, if born after September 15, 2000; regardless of the interval since the last tetanus/diphtheria-containing vaccine.			
Pertussis ^{4, 5}	3 doses, with at least 1 dose received on or after 4 years of age if the applicant was born on or before September 15, 2003 ⁷ ; or 4 doses, with at least 1 dose received on or after 4 years of age if the applicant was born after September 15, 2003 ⁶			
Polio	Polio vaccine is not required for persons 18 years of age or older. 2 doses of measles/rubella-containing vaccine; the first dose shall have been received on or after 12 months of age; the second dose shall have been received no less than 28 days after the first dose; or the applicant demonstrates a positive antibody test for measles and rubella from a U.S. laboratory.			
Measles/Rubella ¹	3 doses			
Hepatitis B	1 dose received on or after 12 months of age if the applicant was born on or after September 15, 1997, but born on or before September 15, 2003, unless the applicant has had a reliable history of natural disease; or 2 doses received on or after 12 months of age if the applicant was born after September 15, 2003, unless the applicant has a reliable history of natural disease. ⁸			
Varicella	1 dose of meningococcal vaccine received on or after 10 years of age for the applicant in grades 7 and above, if born after September 15, 2004; and 2 doses of meningococcal vaccines for the applicant in grade 12, if born after September 15, 1999; or 1 dose if received when the applicant is 16 years of age or older.			
Meningococcal (A, C, W, Y)				

1 Mumps vaccine may be included in measles/rubella-containing vaccine.
 2 DTaP is not indicated for persons 7 years of age or older, therefore, a tetanus and diphtheria-containing vaccine should be used.
 3 The 5th dose of DTaP is not necessary if the 4th dose was administered on or after 4 years of age.
 4 Applicants 7 through 18 years of age who received their 1st dose of diphtheria/tetanus/pertussis-containing vaccine before 12 months of age should receive a total of 4 doses, with one of those doses administered on or after 4 years of age.
 5 Applicants 7 through 18 years of age who received their 1st dose of diphtheria/tetanus/pertussis-containing vaccine at 12 months of age or older should receive a total of 3 doses, with one of those doses administered on or after 4 years of age.
 6 If an applicant received an all-inactivated poliovirus (IPV) or all-oral poliovirus (OPV) series, a 4th dose is not necessary if the 3rd dose was administered on or after 4 years of age.
 7 If both OPV and IPV were administered as part of the series, a total of 4 doses are required.
 8 Administer 2 doses of varicella vaccine, at least 3 months apart, to applicants less than 13 years of age. Do not repeat the 2nd dose if administered 28 days or greater from the 1st dose. Administer 2 doses of varicella vaccine to applicants 13 years of age or older at least 4 weeks apart. The minimum interval between the 1st and 2nd dose of varicella for an applicant 13 years of age or older is 28 days.



PLEASANT VALLEY COMMUNITY SCHOOL DISTRICT

Grades K-6, Student Physical Examination Form

 Last Name First Name Middle Birth date Age Sex

 Parent/Guardian Name

This section to be completed by Physician.								
Height	Weight	BP	Hearing	Vision			Urinalysis	Lead Test
				Left	Right	Both		

Health History		
Allergies	Diseases/Chronic Illnesses	Need Modifications
Food - Contact	Asthma	Medications
Food - Ingestion	Chicken Pox (varicella)	Dietary
Medications	Heart Disease	Special Equipment
Hay Fever	Seizures	Other
Insect Stings	Diabetes	
Other		
Hospitalizations:		
Operations/Serious Illnesses:		
Comments:		

Physical Examination Requirements					
	Normal	Comments		Normal	Comments
Skin			Genito-Urinary		
Ears			Gastrointestinal/Abdomen		
Eyes			Neurological		
Nose/Throat			Musculoskeletal		
Mouth/Dental			Spinal Exam		
Cardiovascular			Nutritional		
Respiratory			Mental Health		
			General Comments		

 Signature of Examining Physician

 Date of Physical