CONCORDIA LUTHERAN SCHOOL

PRESCHOOL • ELEMENTARY SCHOOL • MIDDLE SCHOOL

A Ministry of Concordia Lutheran Church

GRADES 1 - 8 HEALTH FORMS
2025-2026

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ALL FORMS ARE REQUIRED AND SHOULD BE RETURNED TO THE SCHOOL OFFICE NO LATER THAN THE FIRST DAY OF SCHOOL.
***The only exception is the medication consent and that should be returned only if medication is required for school day use.**

ENGAGING HEARTS AND MINDS

4245 LAKE AVENUE ▪ FORT WAYNE, IN ▪ 46815
PHONE: (260) 426-9922 x200 ▪ FAX: (260) 422-6980 ▪ E-MAIL: school@clscubs.org

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General Health Information

Physical Exam/Health Questionnaire

All students new to our school are required to have a recent physical or "Physical Exam Questionnaire" signed by their physician along with the "Health Questionnaire" form filled out by the parents/guardians. **These forms must be submitted to the school office no later than the first day of school.**

CHIRP

As required by IC 20-34-4-6, we report immunizations to the State Department of Health each year on all students in grades K, 1 and 6. This report is currently done online through CHIRP (Children and Hoosier Immunization Registry Program) and we will need a consent signed for each child in order to report this information to the state. **This form needs to be submitted to the school office no later than the first day of school.**

Immunizations

IC 20-34-4-2 requires that **ALL** students have the required immunizations **PRIOR** to, **and on file with the school before the first day of school.** Please obtain an original immunization record from your physician. These immunizations need to be given according to the ACIP (Advisory Committee on Immunization Practices) and the Indiana State Department of Health, this includes proper intervals between each required dose. These minimum doses must be met and they must have been given at the proper minimum age and have the proper intervals between each one to be acceptable for the state school requirements.

The only exception to this rule is a signed "Medical Exemption" form filled out by your child's physician (IC 20-34-3-3) or a "Religious Objection" form signed by the parents/legal guardians (IC 20-34-3-2) stating that it is against your family's religious beliefs. Please contact the nurse if you need either of these forms.

Unfortunately, if this is not completed by the first day of school, you will receive a letter excluding your child from school until the immunizations have been obtained and proper paperwork has been filed.

It is important that you review your child's immunization records now and obtain these necessary immunizations from your child's physician, the Fort Wayne Allen County Department of Health, or any Super Shot location. Remember to provide the school with documentation of all shots received from infancy through the current date.

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When Your Child is Ill

Children with fever, diarrhea, vomiting or other symptoms of illness should stay at home, and, if indicated, be evaluated by the doctor for diagnosis and appropriate treatment. Any fever of **99.9** degrees or above means that your child **must stay home for at least 24 hours** (free of fever **and** without the use of acetaminophen or ibuprofen). This means that if your child was sent home from school the day before with a fever, they need to wait **at least** 24 hours before they will be admitted back to school.

Medications

We will only administer FDA approved over–the–counter (OTC) and prescription medications prescribed to your child (this does not include any herbal medications or narcotic medications). These medications need to be brought to school by an adult in their original package and accompanied by the medication consent form found on our website or in the school office. Medication brought into school will only be available during school hours. Our school policies are in accordance with IC 20-34-3-18. All medication will be kept in a locked cabinet with the nurse, or trained staff member dispensing according to the package instructions. Students are not to have medication with them at any time. The only exception to this is if your child needs emergency medication (ex. insulin, an inhaler or an epinephrine injection) and the proper paperwork is filled out and on file with the school. (Per Concordia Policy, students in 6-8 grade may self-carry with appropriate documentation on file. Forms may be found in the school office or on our website.) If needed, this form requires a signature from your child's physician and is only for their EMERGENCY medication. These policies are in place to keep your child and others in the building as safe as they can be during the school day. A reminder that all cough drops are considered OTC medication and need to be kept in the school office for your child's use. Please read our full medication policy on the reverse side of the "Medication Consent" form.

Please understand that NO medication can be sent home with your child.

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Health Screening Information

During the school year, the following health screenings will take place as part of the health services to your child, and fulfillment of the health screening laws of the State of Indiana. Some students will receive referral letters from the school nurse as the result of these screenings.

Hearing Screenings

Hearing screenings will be conducted according to IC 20-34-3-14, on all students in grades **1, 4, 7, and 10** as mandated by the state. We will also check all students new to the school, and any others by special request. The school nurse, or trained volunteers, will conduct this screening. Re-checks will be done at least 2 weeks later on students who have questionable results and referral letters will be sent to those who do not meet the required thresholds on these rechecks. The school nurse will also notify the teachers of those students that referral letters are sent to.

PLEASE COMPLETE AND RETURN ALL REFERRAL FORMS TO THE ATTENTION OF THE SCHOOL NURSE.

Vision Screenings

Both far and near vision screening will be conducted according to IC 20-31-3-12 for all students in grades **3, 5, and 8**. We will also check all students by special request. The school nurse, or trained volunteers, will conduct this screening. This Indiana Law also requires that **either K or grade 1** be examined by an eye professional, so we have decided to send all of our kindergarten students for the FREE exam that local eye doctors have offered to us. Re-checks will be done on students who have questionable results and referral letters will be sent to those who do not meet the minimum requirements on these rechecks. The school nurse will also notify the teachers of those students that referral letters are sent to.

PLEASE COMPLETE AND RETURN ALL REFERRAL FORMS TO THE ATTENTION OF THE SCHOOL NURSE

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Student Illness Policy

Deciding when to keep your child home from school can be difficult. The intention of this policy is to provide a healthy and safe environment for our students. Some illnesses and situations require a child to be absent from school to prevent the spread of infection to other children and to allow the child time to rest, recover and be treated for the illness. In order to help keep our children healthy, Concordia Lutheran Elementary School requires adherence to the guidelines of this policy.

There are several reasons to keep (exclude) sick children from school:

- The child does not feel well enough to participate comfortably in usual activities, such as extreme signs of tiredness or fatigue, unexplained irritability or persistent crying.
- The child requires more care than the school staff is able to provide without affecting the health and safety of the other children.
- The illness is on the list of symptoms or illness for which exclusion is recommended.
- The child is not vaccinated due to medical or religious reasons and there is an outbreak in the school.

Children will not be allowed to attend school or school related activities if they have anything contagious such as, but not limited to the following:

- FEVER: May return when fever free (99.9 degrees or below) for 24 hours, without medication (examples: fever reducer, ibuprofen, tylenol). This means that if your child was sent home from school the day before with a fever, they need to wait **at least** 24 hours before they will be admitted back to school.
- DIARRHEA / VOMITING: May return when symptom free for 24 hours
- STREP THROAT: May return after 24 hours of antibiotic treatment and no fever for 24 hours
- CONJUNCTIVITIS (pink eye): May return 24 hours after treatment begins and eyes are free of discharge
- HEAD LICE: May return after treatment and removal of all live lice and nits from hair
- RINGWORM: May return after treatment begins; area should be covered while in school for first 48 hours of treatment
- IMPETIGO / STAPH / MRSA: May return 24 hours after treatment starts; wound must be covered with dressing taped on all 4 sides
- COMMUNICABLE DISEASES (such as, but not limited to - influenza, chickenpox, measles, mumps, pertussis, meningitis, mononucleosis): May return when cleared by their medical provider

If a student arrives at school with symptoms, or during the school day begins to show symptoms indicative of a condition listed above, a parent/guardian will be contacted and asked to pick the child up as soon as possible.

The parent/guardian needs to maintain direct contact with the school and the student's teacher if the child is diagnosed with any communicable disease so the school can take appropriate steps to protect the entire student population.

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RETURN TO SCHOOL BEFORE 1ST DAY OF SCHOOL

PHYSICIAN CERTIFICATE OF EXAMINATION FORM

Must be completed by child's physician

Name_____ Date of Birth____/____/____

Allergies_____

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

1._____Dosage_____Time_____

2._____Dosage_____Time_____

3._____Dosage_____Time_____

Height_____ **Weight**_____ **B/P**_____ **Pulse** _____

Eyes _____
Ears _____
Nose _____
Throat _____
Chest/Lungs _____
Heart _____
Abdomen _____
Hernia _____
Extremities _____
Musculoskeletal _____
Neurological _____
Skin _____

Lab Work *(if indicated)*

Hematocrit _____
Hemoglobin _____
Lead Level _____
Sickle Cell _____
Urinalysis _____
Other _____

Tuberculin Test *(if indicated)*

Type of test _____
Date _____
Results _____

Is this student physically fit to participate in all physical education programs?

Yes_____ No_____ If no, please explain_____

Please list any conditions that should be considered in planning this child's school day:

_____

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Student Name _____ **Grade** _____

IMMUNIZATION HISTORY

PLEASE ATTACH A COPY OF THE CHILD'S FULL IMMUNIZATION RECORD

All students must have an immunization record in the school office *before the first day of school*. This student MAY NOT attend school without a record of having received the required immunizations listed below or unless a medical OR religious exemption form has been filed with the school office.

Required vaccinations are as follows:

Kindergarten –5th Grades

DTaP (5) IPV (4) Hepatitis B (3) MMR (2) Varicella (2) Hepatitis A (2)

6th and 8th Grades

Previous listed plus additional Tdap (1) and MCV4 (1)

********These are the minimum doses that are necessary. All minimum ages and intervals for each vaccination as specified in the CDC guidelines must be followed to be considered valid in the State of Indiana .********

_____
Printed/Stamped Name of Physician Completing this Form

_____ _____
Physician's Signature Date

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RETURN TO SCHOOL BEFORE 1ST DAY OF SCHOOL

HEALTH QUESTIONNAIRE

(Parent/Guardian to complete)

Student_____ Grade_____ Date of Birth___/___/___

Address_____ Phone Number_____

Father's Name_____ Mother's Name_____

Student lives with_____

Health History *Check all that apply to your child*

- ❑ ADD/ADHD (circle)
- ❑ Allergy *
  - ❑ Seasonal _____
  - ❑ Food _____
  - ❑ Other _____
- ❑ Asthma *
- ❑ Chickenpox
- ❑ Diabetes *
- ❑ Chronic Ear Infections
- ❑ Emotional Disorder
- ❑ GI/GU Issues
- ❑ Hearing Impairment
- ❑ Hepatitis
- ❑ Measles/Mumps/Rubella
- ❑ Mononucleosis
- ❑ Physical Handicaps
- ❑ Pneumonia
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Seizures *
- ❑ Tuberculosis
- ❑ Vision Impairment
- ❑ Whooping Cough
- ❑ Other _____
  - ❑ Other _____
  - ❑ Other _____
  - ❑ Other _____

**Please note these diagnoses may require a completed action plan form.*

Any checks made above, please give explanations and dates of diagnosis:

_____

_____

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

_____

_____

Please list Allergies _____

Does your child need to use an EPI-PEN due to allergy? _____

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HEALTH QUESTIONNAIRE (Continued)

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

Severe Illnesses: _____

Severe Injuries: (head injury, fractures, etc.):_____

Diagnostic Procedures: _____

Hospitalizations: _____

Surgical Procedures:_____

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 conditions that should be considered in planning your child's school day:

_____

_____

Physician's Name:_____ Phone_____

Dentist's Name:_____ Phone_____

Eye Doctor's 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/Guardian Signature Date

(rev ACNPSA 1/23)

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January 2025

Dear Parents,

Enclosed is a consent form for your child's immunizations to be entered in CHIRP (Child and Hoosiers Immunization Registry Program). CHIRP is the database of children's records when your child has immunizations administered at the Board of Health or Super Shot. Some physicians' offices also input data to CHIRP as well. Your child's immunizations may already be entered into CHIRP, but you will still need to complete the enclosed form. A consent form is needed for each child.

The Indiana Department of Education is requiring all student immunizations to be entered into CHIRP starting with the 2010-2011 school year. Student immunizations have always been reported to the Indiana Department of Education/Health, but in a numerical report that stated the number of students complete or incomplete. All immunizations have been entered for this year's current Kindergarten, 1st, and 6th grade students. In an effort to be efficient with this process we are beginning the entry process for those students who will be enrolled for the 2025-2026 school year.

Please complete the form and return with the other Health Forms in the packet.

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RETURN TO SCHOOL BEFORE 1ST DAY OF SCHOOL

CHIRP Consent Form for Release of Immunization Record

The Indiana State Department of Health maintains an electronic immunization registry entitled Children and Hoosiers Immunization Registry Program (CHIRP). CHIRP allows all health care providers within the state of Indiana to enter and view immunization data with this 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 mandates that all schools within the state of Indiana utilize CHIRP to document annual immunization reports. We are required to submit these immunization reports to maintain our accreditation. We need your consent via this form to add your child to our school data. The Indiana Department of Education's attorney Dana Long, collaborating with the Indiana State Department of Health, has prepared the consent attached to this document.

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 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 of 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.

_____ I hereby consent to the release of such information.

_____ I decline the release of such information.

I, _____ as a parent/legal guardian to the below stated child, give Concordia Lutheran Elementary School permission to release in addition to immunization data, the following information concerning my child to the Indiana State Department of Health's Children and Hoosiers Immunization Registry Program (CHIRP):

_____ _____
Signature Date

_____ _____
Printed Name of Parent(s)/Guardian(s) Address

_____ _____
City, State and Zip Code Printed Legal Name of Child

_____ _____
Birthdate of Child Grade of Child

(rev ACNPSA 1/23)

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RELIGIOUS EXEMPTION FOR IMMUNIZATIONS

Reference Indiana Code Section 20-34-3-2

Student's Name _____ Date of Birth ____/____/____

I have been informed of the immunization requirements stated in the Indiana Code.

I understand that all the required immunizations may be obtained through the Allen County Department of Health, free of charge.

Allen County Department of Health
Immunization Clinic Phone Number 260-449-7504

I understand that for the safety of my student, he/she will be dismissed from class in the event of an epidemic involving a disease that he/she has not been vaccinated against.

Understanding all of the above, I wish to document my objection to my student being immunized against the following diseases:

□ Hepatitis A □ Hepatitis B □ DTap □ Polio □ MMR □ Varicella □ Meningitis

And for the following **religious** reasons *(please be specific)*

_____

_____

I understand that I must file a formal objection annually, in lieu of presenting documentation of immunizations received.

_____ _____ _____

Printed name of Parent/Guardian Signature of Parent/Guardian Date

This signed and dated form must be returned to the school office by the first day of school.

(ACNPSA 1/23)

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VACCINE MEDICAL EXEMPTION

State Form 54648 (4-11) Indiana State Department of Health, Immunization Division

INSTRUCTIONS

1. This form for any child in grades K – 12 who is unable to receive a vaccine required for school entry due to a medical contraindication.

2. Complete and sign form. Submitted to school as proof of exemption from required immunization.

Patient Name _____ Date of Birth *(month/day/year)* _____
Parent/Guardian Name _____ Relationship _____
Street Address _____
City _____ ZIP Code _____ Telephone Number _____

General Contraindications to All Vaccines (*Vaccine(s) should **not** be given.*)

Severe allergic reaction (e.g., anaphylaxis) after a previous vaccine dose or to a vaccine component

□ Hepatitis B (Hep B)	□ Inactivated poliovirus (IPV)	□ Meningococcal, conjugate (MCV4) or Meningococcal, polysaccharide (MPSV4)
□ Diphtheria, tetanus, pertussis (DTaP, Tdap)	□ Measles, mumps, rubella (MMR)	
□ Tetanus, diphtheria (DT, Td)	□ Varicella (Var)	

Which vaccine or vaccine component caused reaction?_____

Type of Clinical Reaction & Date *(month, day year)* _____

Vaccine Specific Contraindications *(Vaccine should **not** be given.)*

DTaP or Tdap	□ Encephalopathy (e.g., coma, decreased level of consciousness, prolonged seizures) not attributable to another identifiable cause within seven (7) days of administration of previous dose of DTP or DTaP
MMR	□ Pregnancy Estimated Date of Confinement: _____ *(month, day, year)* □ Known severe immunodeficiency (e.g., hematologic and solid tumors; receiving chemotherapy; congenital immunodeficiency; long term immunosuppressive therapy; or patients with HIV infection who are severely immunocompromised)
Varicella	□ Pregnancy Estimated Date of Confinement: _____ *(month, day, year)* □ Substantial suppression of cellular immunity

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Vaccine Specific Precautions (*Vaccine may be given or held depending on clinical situation.*)

DTaP	□ Guillan-Barre syndrome (BGS) within six (6) weeks after previous dose of tetanus-containing vaccine. □ History of Arthus-type hypersensitivity reaction following a previous dose of tetanus and/or diphtheria toxoid-containing vaccine: defer vaccination until at least ten (10) years have elapsed since the previous dose. □ Progressive or unstable neurological disorder, uncontrolled seizures or progressive encephalopathy: defer vaccination with DTaP or Tdap until after a treatment regimen has been established and the condition has stabilized.
DTaP or Tdap	□ Temperature of >= 105F within forty-eight (48) hours after vaccination with previous dose of DTP/DTaP □ Collapse and shock-like state (i.e. hypotonic hyporesponsive episode) within forty-eight(48) hours after previous dose of DTP/DTaP □ Seizure or convulsion within three (3) days after receiving a previous dose of DTP/DTaP □ Persistent, inconsolable crying lasting three (3) or more hours within forty-eight (48) hours after previous dose of DTP/DTaP
MMR	□ Recent (within eleven (11) months) receipt of anti-body containing blood product (interval depends on product) □ History of thrombocytopenia or thrombocytopenia purpura
Varicella	□ Recent (within eleven (11) months) receipt of anti-body containing blood product (interval depends on product) □ Receipt of specific antivirals (i.e. acyclovir, famciclovir, or valacyclovir) twenty-four (24) hours before vaccination; if possible, delay resumption of these antiviral drugs for fourteen (14) days after vaccination.

Other Medical Contraindication (*Must list vaccine(s) and contraindications individually)*

Vaccine	**Specific Contraindication**

Please indicate the duration of the medical exemption, and if and when vaccine can be safely administered.
(Exemption can last for a maximum of one (1) year, and a new form must be completed annually if medical exemption still applies.)

□ Medical exemption is permanent, and will apply for one (1) year from today's date.

□ Medical exemption is temporary (<1 year), and resolution is anticipated by ____/____/____

□ Medical exemption is pregnancy, and Estimated Date of Confinement (EDC) is ____/____/____

Physician Name _____ Physician License Number _____

Office Address _____ Telephone _____

Physician Signature _____ Date *(month, day year)* _____

Engaging Hearts and Minds

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STUDENT MEDICATION INFORMATION AND CONSENT FORM

I have read and understand the medication policies as indicated on the reverse side.

Prescription Medication(s)
Please administer to my child (printed name) _____, the medication as prescribed below by my child's healthcare provider. The label affixed to the medication bottle/package will meet the requirement for the physician's written order.

AND / OR

Over-The-Counter Medication(s)
Please administer to my child (printed name) _____, the medication as described below.

REMINDER: Prescription and over-the-counter medications must be kept in the original container with the pharmacy or brand label affixed. Medications will only be given as either prescribed by the practitioner or the FDA instructions that are found on the OTC medication label.

NO MODIFICATIONS OF DOSAGE OR FREQUENCY WITHOUT THE WRITTEN CONSENT BY THE CHILD'S HEALTHCARE PROVIDER.

Medication Name	Dosage (mg & # of tabs)	Time to Be Given	Date Medication To Be Discontinued	Reason for Medication	Precautions / Side Effects
Example: Pepcid	10 mg	12 noon	8/15	Acid Reflux	Dry Mouth
1.					
2.					
3.					

_____ _____
Parent/Guardian Signature Date

FULL MEDICATION POLICY ON REVERSE SIDE

(revised ACNPSA 1/23)

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MEDICATION POLICIES AND
WRITTEN CONSENT FOR ADMINISTRATION OF MEDICATION

In order to protect the health and welfare of the students and school staff alike, Indiana laws require that parents/guardians consent, in writing, to the administration of medication. In order for the school nurse, volunteer school nurse, or a staff member to administer medications to your student, the medication form on the reverse side must be completed and signed. Please read carefully the school policies regarding medication administration during school hours.

The day-to-day health needs of the students are cared for by the school office personnel. We have a volunteer nurse who assists us with immunizations, vision, and hearing screenings, but a school nurse is not on-site during school hours. As such we are not able to provide the same healthcare as a registered nurse.

1. The school **must have on record a written prescription order from the prescribing physician/practitioner and written consent** from the parent/guardian for prescription medications. There must be a written consent from the parent/guardian for Over-the-Counter (OTC) medications before they will be administered to a student at school. (NOTE: The label on the prescription bottle/package will meet the requirement for physician's written order.)
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, and prescribing physician/ practitioner (if applicable).
3. Herbal and narcotic medications will not be given at school.
4. Medication brought to the school must be checked in at the office and kept in a locked cabinet.
5. Bring in only **enough prescription medication for one week** to accommodate the dose amounts for the established time frame, and only **enough OTC medication to cover one week** of doses.
6. The parent/guardian shall accept the legal responsibility for the safe arrival of his/her child's medication to the school. Medication (OTC and/or prescribed) need to be provided and brought in **by the parent/guardian, not the student**.
7. The school nurse/assigned staff member must be aware of the purpose for which the student is receiving the medication.
8. In specific cases, the school nurse/assigned staff member may require the parent/guardian to come to the school to administer the medication.
9. No school employee, other than the school nurse, will give injections, unless appropriate training has been given.
10. 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 cannot take a physician order over the phone.
11. 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.
12. Self administration of medication will be determined by student age and ability to do so safely. Per Concordia Policy, students in 6-8 grade may self-carry with appropriate documentation on file. Administration/staff will reserve the right to request a student medication administration be supervised, even if the student administers their own medication at home.

IC 20-34-3-18 Indiana State Code reads that a school corporation MAY NOT send home with a student medication that is possessed by a school for administration during school hours or at school functions. Medication that is possessed by a school for administration during school hours or at school functions for a student in grades kindergarten through grade 8 may be released only to:

The student's parent/guardian OR an individual who is at least 18 years of age **and**, designated, **in writing,** by the student's parent/guardian to receive the medication. (reviewed ACNPSA 1/23)

ENGAGING HEARTS AND MINDS

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