School: _____

For Office Use ONLY			
GLO Code:	*(Circle)*	AM	PM
Date:			
Time:		Position in line #	

SHAWNEE MISSION
SCHOOL DISTRICT

Shawnee Mission School District
Pre-K Enrollment Checklist

The following information is required to complete your child's pre-K enrollment 2020-2021

_____District Enrollment Package

_____Identity of Student (Original birth certificate or passport)

_____Health/Immunization Records (Students cannot start school without immunizations and doctor's physical exam records on file)

_____Proof of Residency (Lease Agreement or Mortgage Statement) A notarized Verification of Residency form with proof of residency of person family is living with. [i] (See below). School secretary will provide the packet.

_____ Two recent **utility** bills (electric, gas or water), within the last 45 days (Note: if these utilities are included in your apartment rental fees then two secondary utility bills [i.e. cable, phone] should be provided.)

_____ Legible copy of Kansas driver's license/ID or government issued photo ID

_____ Screening Document (to be done at school)

_____IPT (ELL Proficiency Test - to be done at school). For English Language Learners only

[i] All parents/guardians who are residing with another family within the Shawnee Mission School District boundaries will be required to have a notarized Residency Provider Statement to verify proof of residency. The Residency Provider Statement will be reviewed by the SMSD Residency Hearing Officer. Please request the forms in your school office and contact the Residence Provider Officer Jordan Hardman 913-993-7986 or the Early Childhood Education Department at 913-993-6441 to schedule an appointment.

SHAWNEE MISSION
SCHOOL DISTRICT

Shawnee Mission Pre-K Application Form - 2020-2021

Morning or Afternoon (check one) ☐ **AM (8:15-11:00)** ☐ **PM (12:15-3:00)**

Student's Name: _____
Parent Name: _____ **Date of Birth:** _____
Street Address: _____ **City:** _____
Homeschool: _____ **State, Zip:** _____

Parent Phone Numbers
Home: **Work:** **Cell:**

Parent Email Address:

Please indicate if your child has an IEP ☐ **YES** ☐ **NO**
Circle one

Enrollment Criteria

All applicants must reside in the Shawnee Mission School District and be 4 years of age on or before August 31, 2020. Students turning 5 on or before August 31, 2020 are **not** eligible for enrollment. Students must be independent with toileting. Students must meet one or more of the following criteria in order to be considered for enrollment in no-fee pre-K. Please check all that apply.

☐ 1 *Our family qualifies for the free lunch program.
☐ 2 *Family qualifies for reduced lunch support. *Applies to Highlands and Santa Fe Trail ONLY.*
☐ 3 On the first day of school, a custodial parent is unmarried.
☐ 4 *Student has been referred by DCF for educational services.
☐ 5 At least one parent was a teen when the child was born.
☐ 6 A parent is lacking a GED or high school diploma.
☐ 7 *The child has limited English proficiencies based on ELL assessment.
☐ 8 *The student is developmentally or academically delayed based on validated assessment, but above the eligibility criteria for SPED services. *Scores that fall at or below the 40th percentile indicate 'at-risk'.*
☐ 9 *Student qualifies for services under the Migrant Education Program.
☐ 10 *Our family lives in a Title I school attendance area. *Circle which one: Apache IS, Comanche, Crestview, Merriam Park, Nieman, Overland Park, Rosehill, or Shawanoe.*
☐ 11 *Child experiencing homelessness. *Students must meet McKinney-Vento eligibility criteria, for more information contact David Aramovich, McKinney-Vento liaison at 913-993-8675.*

For Office Use Only
ELL IPT Test Complete on:
_____
Score: A B C D E (circle one)
Tester Initials _____

***Verification of qualifying criteria must occur before a student is placed in pre-K.**
If your family doesn't meet the qualifying criteria, ask the secretary about tuition-based pre-K option.

We will begin accepting enrollment applications for pre-kindergarten on February 18. Please bring your child along with the completed application to enroll.

Completed district enrollment packets will be accepted on a first come, first served basis. Parents will be notified regarding acceptance into the program. *I realize that I am not guaranteed an AM or PM placement or a location of choice. All placements will be final. I understand that I am responsible for transportation of my child to and from school.

_____ _____
Parent Signature **Date**

SHAWNEE MISSION SCHOOL DISTRICT

STUDENT ENROLLMENT FORM

FOR OFFICE USE ONLY - SCHOOL INFORMATION START DATE _____

STUDENT NO_____SCHOOL YEAR_____SCHOOL NAME _____HOME ROOM _____ GRADE_____

NEW ENROLLMENT ☐ RE-ENTRY ☐ LOCKER #_____

Please **PRINT** clearly in unshaded areas

STUDENT INFORMATION

LEGAL LAST NAME SUFFIX (JR II etc.)	FIRST NAME	MIDDLE NAME	COMMON NICKNAME

DATE OF BIRTH (MM/DD/YEAR)	GENDER (M/F)	BIRTH STATE (OR COUNTRY IF NOT UNITED STATES)

ETHNICITY (SELECT ONE)	RACE (CHECK ALL THAT APPLY)		
☐ No, not Hispanic/Latino	☐ White	☐ Black/African American	☐ Asian
☐ Yes, Hispanic/Latino	☐ Native Hawaiian/other Pacific Islander		☐ American Indian/Alaskan Native

PRIMARY LANGUAGE SPOKEN : OTHER LANGUAGE SPOKEN AT HOME:

SCHOOL LAST ATTENDED _____IS STUDENT CURRENTLY UNDER LONG-TERM SUSPENSION OR EXPULSION? ☐ YES ☐ NO

HAS STUDENT ATTENDED A SHAWNEE MISSION SCHOOL PREVIOUSLY? ☐ YES ☐ NO

PLEASE INDICATE IF STUDENT HAS AN I.E.P. ☐ YES ☐ NO PLEASE INDICATE IF STUDENT HAS A 504. ☐ YES ☐ NO

FAMILY INFORMATION

COURT ORDER REGARDING CUSTODY? ☐ YES ☐ NO (Non-custodial parent may have access to student information unless prohibited by court order. The school must have a copy of the legal documents if access is prohibited.)

DO YOU WISH TO RESTRICT STUDENT/FAMILY INFORMATION? ☐ YES ☐ NO (If you choose to restrict your student/family information, your student's name will not appear in the student directory and his/her name will not be provided to outside agencies including the U.S. military or colleges/universities.)

DOES STUDENT HAVE A PARENT ON ACTIVE DUTY IN THE U.S. MILITARY? ☐ YES ☐ NO

PRIMARY RESIDENCE CONTACT INFORMATION

HOME ADDRESS	**CITY**	**STATE**	**ZIP**

GUARDIAN 1 LAST NAME	FIRST NAME	MIDDLE NAME	RELATIONSHIP TO STUDENT

PRIMARY PHONE NUMBER	SECONDARY PHONE NUMBER	ADDITIONAL PHONE NUMBER
( )_____-_____	( )_____-_____	( )_____-_____
☐HOME ☐WORK ☐CELL ☐OTHER	☐HOME ☐WORK ☐CELL ☐OTHER	☐HOME ☐WORK ☐CELL ☐OTHER

EMAIL ADDRESS : **EMPLOYER:**

GUARDIAN 2 LAST NAME	FIRST NAME	MIDDLE NAME	RELATIONSHIP TO STUDENT

PRIMARY PHONE NUMBER	SECONDARY PHONE NUMBER	ADDITIONAL PHONE NUMBER
( )_____-_____	( )_____-_____	( )_____-_____
☐HOME ☐WORK ☐CELL ☐OTHER	☐HOME ☐WORK ☐CELL ☐OTHER	☐HOME ☐WORK ☐CELL ☐OTHER

EMAIL ADDRESS : **EMPLOYER:**

SECONDARY RESIDENCE CONTACT INFORMATION

HOME ADDRESS	**CITY**	**STATE**	**ZIP**

GUARDIAN 1 LAST NAME	FIRST NAME	MIDDLE NAME	RELATIONSHIP TO STUDENT

PRIMARY PHONE NUMBER	SECONDARY PHONE NUMBER	ADDITIONAL PHONE NUMBER
( )_____-_____	( )_____-_____	( )_____-_____
☐HOME ☐WORK ☐CELL ☐OTHER	☐HOME ☐WORK ☐CELL ☐OTHER	☐HOME ☐WORK ☐CELL ☐OTHER

SECONDARY RESIDENCE CONTACT INFORMATION, continued

GUARDIAN 2 LAST NAME	FIRST NAME	MIDDLE NAME	RELATIONSHIP TO STUDENT

PRIMARY PHONE NUMBER	SECONDARY PHONE NUMBER	ADDITIONAL PHONE NUMBER
( )_____-_____	( )_____-_____	( )_____-_____
☐HOME ☐WORK ☐CELL ☐OTHER	☐HOME ☐WORK ☐CELL ☐OTHER	☐HOME ☐WORK ☐CELL ☐OTHER

EMAIL ADDRESS : **EMPLOYER:**

ADDITIONAL RESIDENCY INFORMATION

This section addresses the McKinney-Vento Act. Where is the student currently living? (check only one)

☐ In a shelter_____ (name shelter)	☐ Alone without parental support(independent living student)	☐ **Temporarily** with more than one family in a house, mobile home, or apartment because the family doesn't have a place of their own.
☐ In a motel, car, or campsite	☐ **Temporarily** with more than one family (due to loss of job, housing etc.)	☐ None of these apply
☐ In temporary foster care awaiting permanent placement		

ALL CHILDREN RESIDING AT RESIDENCE

	LAST NAME	FIRST NAME	BIRTHDATE	SCHOOL
1.			___/___/____	
2.			___/___/____	
3.			___/___/____	
4.			___/___/____	

MIGRANT ELIGIBILITY

1. Does anyone in your family work in agriculture, including at a greenhouse or nursery? ☐ Yes ☐ No
2. If yes, have you moved within the past three years? ☐ Yes ☐ No

EMERGENCY CONTACT INFORMATION (In case of emergency or illness when parent cannot be reached)

#1 LAST NAME	FIRST NAME	TITLE	RELATIONSHIP TO STUDENT

PRIMARY PHONE NUMBER	SECONDARY PHONE NUMBER	ADDITIONAL PHONE NUMBER
( )_____-_____	( )_____-_____	( )_____-_____
☐HOME ☐WORK ☐CELL ☐OTHER	☐HOME ☐WORK ☐CELL ☐OTHER	☐HOME ☐WORK ☐CELL ☐OTHER

#2 LAST NAME	FIRST NAME	TITLE	RELATIONSHIP TO STUDENT

PRIMARY PHONE NUMBER	SECONDARY PHONE NUMBER	ADDITIONAL PHONE NUMBER
( )_____-_____	( )_____-_____	( )_____-_____
☐HOME ☐WORK ☐CELL ☐OTHER	☐HOME ☐WORK ☐CELL ☐OTHER	☐HOME ☐WORK ☐CELL ☐OTHER

#3 LAST NAME	FIRST NAME	TITLE	RELATIONSHIP TO STUDENT

PRIMARY PHONE NUMBER	SECONDARY PHONE NUMBER	ADDITIONAL PHONE NUMBER
( )_____-_____	( )_____-_____	( )_____-_____
☐HOME ☐WORK ☐CELL ☐OTHER	☐HOME ☐WORK ☐CELL ☐OTHER	☐HOME ☐WORK ☐CELL ☐OTHER

I understand that knowingly providing false information on this form may result in criminal prosecution under Kansas Statute § 21-5824, which prohibits the making of false information with the intent to defraud or induce official action – a FELONY.

I will notify the school office immediately or within three (3) business days, if at any time this student moves from the primary residence listed above or changes address.

SIGNATURE_____ DATE_____

Date of Birth_____

Free/Reduced Lunch As Only Qualifier

If you checked,

☐ 1 Our family qualifies for **free** lunch program

and/or

☐ 2 Our family qualifies for **reduced** lunch support *(Applies to Highlands and Santa Fe Trail Elementary ONLY)*

As your ONLY qualifier, please note that verification of qualifying criteria must occur before a student is placed in pre-K.

1) **Submit** your Free/Reduced lunch application that becomes available online by July 13, 2020 at https://www.smsd.org/about/departments/food-service/free-reduced-meals,

or you may visit the district food services office located at 6701 W. 83rd Street to complete a paper application, and receive assistance with the process.

2) Forward the confirmation email from food services indicating your family has qualified for Free/Reduced meals, to susanabelvedere@smsd.org. Please submit the approval confirmation as soon as you receive it but by no later than July 24, 2020.

Failure to provide the confirmation letter will result in your child being removed from the No-fee pre-K program.

If your family does not qualify, parents are welcome to contact Susana Belvedere (913) 993-6441 to discuss the tuition-based pre-K option.

_____ _____

Parent Signature Date

Free/Reduced Lunch As Only Qualifier

(Parent Copy)

If you checked,

☐ 1 Our family qualifies for **free** lunch program

and/or

☐ 2 Our family qualifies for **reduced** lunch support *(Applies to Highlands and Santa Fe Trail Elementary ONLY)*

As your ONLY qualifier, please note that verification of qualifying criteria must occur before a student is placed in pre-K.

1) **Submit** your Free/Reduced lunch application that becomes available online by July 13, 2020 at https://www.smsd.org/about/departments/food-service/free-reduced-meals,

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Failure to provide the confirmation letter will result in your child being removed from the No-fee pre-K program.

If your family does not qualify, parents are welcome to contact Susana Belvedere (913) 993-6441 to discuss the tuition-based pre-K option.

HOME LANGUAGE SURVEY

Upon enrollment, every student or parent/guardian must be given a Home Language Survey. This survey will be used to determine which students should be assessed for English proficiency. Knowledge of, or exposure to another language does not, in and of itself, qualify a student for ESOL services. If a language other than English is indicated in any of questions 1-4, the student will be assessed to determine eligibility for English for Speakers of Other Languages (ESOL) services. If a student scores below proficient/fluent in any of the language domains: listening, speaking, reading, or writing, s/he is eligible for ESOL services. Please complete one form for each child.

Student Information:

Name		Grade
Address		Date of Birth
Date first enrolled in a school in the U.S	**U.S. Entry Date**	Phone Number

Student Language Information:

1. What language did your child first learn to speak/use?
   English ☐ Spanish ☐ Other (please specify) _____
2. What language does your child speak/use at home?
   Do not include language learned in a class or through television or other such.
   English ☐ Spanish ☐ Other (please specify) _____
3. What language do you speak/use with your child?
   English ☐ Spanish ☐ Other (please specify) _____
4. What language do the adults regularly present or living in the home speak/use while in presence of the child?
   English ☐ Spanish ☐ Other (please specify) _____

Office Use Only

If any answer to questions 1-4 indicates a language other than English,

1) Contact your Reading Specialist or ELL Aide to schedule an IPT evaluation

2) Email this form to mariamcintyre@smsd.org

Parent/Guardian Information:

Which language do you prefer? English ☐ Spanish ☐ Other (specify)_____
(Please specify "written" or "spoken". To the extent practicable, communication from the school will be provided in this language).

Migrant Education Program Information:

The Migrant Education Program (MEP) is authorized by Title I Part C of the Elementary and Secondary Education Act of 1965 (ESEA). The MEP provides formula grants to local education agencies to establish or improve education programs for children who may qualify for the Migrant Program. Please help us determine your child's eligibility for the Migrant Program by responding to the following questions.

Have you or a member of your family moved in the last 36 months to do, or apply for, agriculture or fishing related work, including dairies, nurseries, meat or vegetable processing, feed yards, or field work? Yes ☐ No ☐

Have your child moved with or to join the worker above in the past 36 months?
Yes ☐ No ☐

Office Use Only

Home School: _____

All Home Language Surveys are to be filed in the student's cumulative folder.

**See the reverse side of this form for additional information regarding student language information*

Parent Signature **Date**

_____ _____

SHAWNEE MISSION
SCHOOL DISTRICT

Purpose and Intent of the Home Language Survey

"The home language survey questions attempt to inform the district of the possible impact on a child's English language development due to transfer, influence, or exposure to a language other than English. It is not at all assumed that a child who has a language other than English is less proficient in English as a result of knowing another language.

The questions are not intended to identify children who are learning a language other than English by watching educational media that teach languages, words, or phrases other than English. The questions are also not intended to identify children who are studying a world language for the purpose of becoming bilingual or more knowledgeable about languages other than English. Examples may include taking a Saturday German class, or taking Spanish as a graduation requirement in high school, or being instructed informally by someone in the home who wishes to encourage a child to learn another language."

Kansas Department of Education, January 9, 2013

SHAWNEE MISSION
SCHOOL DISTRICT

Health History Form

Student's Name	Birthdate / /	Age	Sex (M/F)	Grade

Mother/Guardian _____	Father/Guardian _____
Cell Phone: (_____)_____-_____	Cell Phone: (_____)_____-_____
Home Phone: (_____)_____-_____	Home Phone: (_____)_____-_____
Work Phone: (_____)_____-_____	Work Phone: (_____)_____-_____

Name of Physician _____ Phone (____)_____-_____
Name of last school attended _____City/State_____

Special Healthcare Planning/Serious Health Conditions Please notify the school nurse of a serious or life threatening health condition prior to the start of school.

☐ Allergy/Anaphylaxis: My child has severe allergy/anaphylaxis requiring an Epi Pen/Auvi-Q prescription.
Describe the allergy (food, insect, etc.) _____
☐ Asthma: ☐ Yes ☐ No My child uses rescue inhaler routinely for asthma symptoms
☐ Yes ☐ No My child has been hospitalized in the past year for asthma
☐ Yes ☐ No My child has needed steroids (prednisone) for asthma symptoms in the past year
☐ Diabetes: Date of diagnosis: _____My student has: ☐ insulin pump ☐ insulin pen ☐ injected insulin
☐ Seizure Disorder: My student needs emergency medication for seizures. Name of medication: _____
☐ Other: My child has special health care needs: wheel chair, tube feedings, breathing tube, catheter, intravenous tubes, other. Please describe your child's condition and healthcare needs: _____

Other Health Conditions Check any condition your child currently has or has had in the past:

☐ ADD/ADHD	☐ Depression/Anxiety (circle one)	☐ Orthopedic/Bone
☐ Allergies ☐ Seasonal	☐ Dental ☐ Braces/Orthodontia	☐ Serious Injury
☐ Dietary Restrictions	☐ Ear Infections ☐ Ear Tubes	☐ Surgery(s)
☐ Bladder/Bowel	☐ Hearing Impairment ☐ Hearing Aides	☐ Social/Emotional/Behavioral
☐ Blood Disorder	☐ Headaches/Migraines	☐ Stomach Aches
☐ Concussion	☐ Heart Disease	☐ Throat Infections
☐ Cancer	☐ Kidney Disease	☐ Vision ☐ Glasses ☐ Contacts

Explain any health condition(s) checked _____
Does your child require any restriction of physical activity in school? ☐ No ☐ Yes, specify nature and duration of restriction:
_____

Emergency Contact (if parent/guardian cannot be reached)

1. Name _____ Relationship_____ Phone (____)_____-_____
2. Name _____ Relationship_____ Phone (____)_____-_____

Preferred Hospital _____City/State_____

Statement of Consent

In the event of an emergency, I give my permission for the transfer of health information to appropriate school or healthcare professionals including emergency personnel. This includes release of school immunization records to the KS Immunization Program, and the immunization registry for the purpose of assessment, reporting, and prevention of disease. This does not include data regarding individual student. I authorize school personnel to obtain emergency medical care for my student in the event I cannot be reached.

Print Parent/Guardian Name	Signature of Parent/Guardian	Date / /

Revised 01/2020

SHAWNEE MISSION
SCHOOL DISTRICT

PHYSICAL EXAMINATION STATEMENT

Name of Student _____

TO: Principal/Nurse of _____

I, the parent/guardian of _____, am affirming that I understand that the Kansas statute states that the above named student is required to have a physical examination within ninety (90) days after school enrollment or show proof that one has been conducted within 12 months prior to enrollment.

I further understand that if the results of a physical examination are not forwarded to the school nurse or principal by the date noted below, the student will be excluded from school.

Parent/Guardian Signature _____

Date _____

SHAWNEE MISSION
SCHOOL DISTRICT

Immunization Statement

Name of Student _____

To: Principal/Nurse of _____

I, the parent/guardian of _____, state that all tests and/or inoculation required by Kansas School Immunization Laws 72-5208, 72-5209, as amended in 1992, are in the process of being received. Records indicating completion of all required immunizations according to Kansas Certificate of Immunization will be in the school nurse's office within sixty (60) days after enrollment to school.

All students enrolling in the Shawnee Mission School District for the first time, must show written proof that they have received at least one dose of each of the immunizations required by the state of Kansas before they may attend any classes.

I further understand that if I have not presented information showing immunizations are up to date within 60 days of enrollment, the student will be excluded from school until proof of required immunizations is provided.

Parent/Guardian Signature _____

Date Signed _____

SHAWNEE MISSION
SCHOOL DISTRICT

MEDICATION PERMISSION FORM

Student Name | Birthdate | Grade | School Year

OVER-THE-COUNTER MEDICATION

By initialing below, I give permission for school personnel to administer the following medication(s) as needed to my student for minor discomfort or injury. Medications supplied by school may vary between buildings and grade levels.

_____ Acetaminophen (Tylenol)
_____ Ibuprofen (Advil or Motrin)
_____ Cough drop (non-medicated)
_____ Topical medication (antibiotic ointment, calamine lotion, hydrocortisone cream)
_____ Antacid (Tums)
_____ Eye drop (non-medicated lubricating)
_____ Antihistamine oral (diphenhydramine, cetirizine)
_____ Antihistamine allergy eye drops

Parents may also supply other over-the-counter medications. Please list below:

Medication name: _____ Dosage: _____
Reason given: _____ Time: _____

Medication name: _____ Dosage: _____
Reason given: _____ Time: _____

PRESCRIPTION MEDICATION

Medication name: _____ Dosage: _____
Reason given: _____ Time: _____

Medication name: _____ Dosage: _____
Reason given: _____ Time: _____

On early dismissal or late start days please indicate one of the following:

☐ Do NOT administer medication on early dismissal days
☐ Do NOT administer medication on late start days
☐ Administer medication at adjusted lunch time
☐ Administer medication at prescribed time

To ensure continuity of care, I give permission for the school nurse to communicate with my student's healthcare provider regarding medication administration at school.

Physician name: Phone number:

Physician signature (required if no Rx label):

School personnel who administer medication according to proper dosing instructions shall be held harmless for any adverse reaction experienced by the student. My student has previously taken the medications(s) listed above with no known adverse reaction.

Parent/guardian printed name:

Parent/guardian signature: Date:

SHAWNEE MISSION
SCHOOL DISTRICT

Medication Administration Guidelines

Permission: Written permission from the parent or guardian must be on file for all medications given at school, including over-the-counter (OTC) medications. Authorization must be renewed every school year.

Medication: Only FDA approved prescription and OTC medications are allowed to be administered by school personnel. OTC medications will be given per package label dosing instructions, unless prescribed by a physician.

Container: Prescription medication brought to school must be in the original container with a current prescription label on the bottle including the child's name, doctor's name, date, medication name, dosage, and time to be given. Controlled substances must be submitted with a Medication Count Form. OTC medications provided by parent must be in the original container and labeled with the student’s name.

Division of Public Health
Curtis State Office Building
1000 SW Jackson St., Suite 300
Topeka, KS 66612-1368

Kansas Department of Health and Environment

Phone: 785-296-1086
www.kdheks.gov

Lee A. Norman, M.D., Acting Secretary

Laura Kelly, Governor

LICENSED CHILD CARE FACILITIES AND EARLY CHILDHOOD PROGRAMS OPERATED BY SCHOOLS IMMUNIZATION REQUIREMENTS FOR 2019-2020 SCHOOL YEAR

Immunization requirements and recommendations for the 2019-2020 school year are based on the Advisory Committee on Immunization Practices (ACIP) and the Centers for Disease Control and Prevention (CDC) recommendations. The current recommended and minimum interval immunization schedules may be found on the CDC webpage. The best disease prevention is achieved by adhering to the recommended schedule. However, if a child falls behind, the minimum interval schedule is implemented. To avoid missed opportunities, immunization providers may use a 4-day grace period, in most instances, per age and interval between doses. In such cases, these doses may be counted as valid.

K.A.R. 28-1-20 defines the immunizations required for children attending child care facilities and early childhood program licensed by the Kansas Department of Health and Environment. The complete regulation is published in the June 26, 2008 Kansas Register.

- **Diphtheria, Tetanus, Pertussis (DTaP):** Five doses required. Doses should be given at 2 months, 4 months, 6 months, 15-18 months, and 4-6 years (prior to kindergarten entry). The 4th dose may be given as early as 12 months of age, if at least 6 months have elapsed since dose 3. The 5th dose is not necessary if the 4th dose was administered at age 4 years or older.
- **Haemophilus influenzae type b (Hib):** Three to four doses required for children less than 5 years of age. Brands of vaccine approved for a three-dose series should be given at 2 months, 4 months, and 12-15 months. Brands of vaccine approved for a four-dose series should be given at 2 months, 4 months, 6 months, and 12-15 months. Total doses needed for series completion is dependent on the type of vaccine administered and the age of the child when doses were given.
- **Hepatitis A:** Two doses required. Doses should be given at 12 months with a minimum interval of 6 months between the 1st and 2nd dose.
- **Hepatitis B:** Three doses required. Doses should be given at birth, 1-2 months, and 6-18 months. Minimum age for the final dose is 6 months.
- **Measles, Mumps, and Rubella:** Two doses required. Doses should be given at 12-15 months and 4-6 years (prior to kindergarten entry). Minimum age is 12 months and interval between doses may be as short as 28 days.
- **Pneumococcal conjugate (PCV):** Four doses required for children less than 5 years of age. Doses should be given at 2 months, 4 months, 6 months, and 12-15 months. Total doses needed for series completion is dependent on the age of the child when doses were given.
- **Poliomyelitis (IPV/OPV):** Four doses required. Doses should be given at 2 months, 4 months, 6-18 months, and 4-6 years (prior to kindergarten entry). Three doses are acceptable if 3rd dose was given after 4 years of age **and** at least 6 months have elapsed since dose 2.
- **Varicella (chickenpox):** Two doses are required. Doses should be given at 12-15 months and 4-6 years (prior to kindergarten entry). The 2nd dose may be administered as early as 3 months after the 1st dose, however, a dose administered after a 4-week interval is considered valid. No doses are required when student has history of varicella disease documented by a licensed physician.

Legal alternatives to school vaccination requirements are found at K.S.A. 72-6262.
In addition to the immunizations required for children attending child care facilities licensed by KDHE and early childhood programs operated by schools, other vaccine recommendations are:

- **Rotavirus:** Two or three doses are recommended for < 8 months of age; not required. Total doses needed for series completion is dependent on the type of vaccine administered and the age of the child when doses were given.
- **Influenza:** Annual vaccination recommended for all ages ≥ 6 months of age. Number of doses is dependent on age and number of doses given in previous years.

Vaccination efforts by school and public health officials, immunization providers and parents are key to the success of protecting our children and communities from vaccine preventable disease. Thank you for your dedication.

Rev. 2/12/2019

SHAWNEE MISSION
SCHOOL DISTRICT

Physical Exam Record

To be completed by certified healthcare professional

Student's Name	Date of Birth / /	Age	Sex (M/F)	Grade

Does the child have a diagnosed medical condition? ☐ No ☐ Yes
Specify:

Does the child have a health condition that may require EMERGENCY ACTION while at school? ☐ No ☐ Yes
(e.g.: seizure, severe allergic reaction, diabetes)
Specify:

Is the child on prescription medication? ☐ No ☐ Yes
Specify medication and diagnosis:

Are any immunization, booster, or revaccinations indicated? ☐ No ☐ Yes
Specify type and due date:

Does the child have history of chicken pox disease? ☐ No ☐ Yes
Specify date:

Does the child require any restriction of physical activity in school? ☐ No ☐ Yes
Specify nature and duration of restriction:

EXAM FINDINGS/CONCERNS

Physical Exam	WNL	ABNL	Area of Concern	Health Area Of Concern	Yes	No	Referred for Evaluation
Head				Developmental			
Eyes				Mobility			
ENT				Speech/language			
Neuro				Hearing			
Dental				History of frequent ear infections			
Respiratory				Vision			
Cardiac				Nutrition			
GI/GU				History of traumatic head injury			
Abdomen				Signs of acanthosis nigricans			
Endocrine				Learning disability			
Skin				Attention deficit hyperactivity disorder (ADHD)			
Genital				Psychosocial			
Orthopedic				Other:			

Please explain any abnormal or area of concern findings:

SCREENING RESULTS

Height: ft. in.	Weight: lbs.	Body Mass Index (BMI):	
Blood Pressure:		Vision: L 20/ R 20/ Both 20/ Glasses ☐ Contacts ☐	
Print Name		**Signature of Healthcare Provider**	**Date** / /

State law (K.S.A. 72-5214) requires all children up to the age of nine entering a Kansas public school for the first time present results of a health assessment prior to school entry.

Revised 3/2017