GET READY FOR KINDERGARTEN

Don't forget about one of the most important school supplies...GOOD VISION! Take advantage of these Kindergarten vision exam specials by local clinics.

VISION EXAM: Why? A vision examination by a qualified physician is **required prior to entering Kindergarten.** A parent or guardian who objects may submit a written statement of refusal for his or her child. Waiver forms are available in the school health office.

- If you have vision coverage (private insurance or Medicaid), the clinics listed below will file accordingly and you will be responsible for any remaining amount not covered.
- If you do not have vision coverage, please inform the school nurse, (308) 884-2247, regarding a vision screening certificate available to be used at the clinics listed below. The program is sponsored by VSP "Sight for Students" to cover a complete eye exam and glasses if needed.

Blackburn Eye Clinic

- **When:** Monday, Tuesday, Wednesday, or Friday
  - By appointment only (308-254-3225)
- **Where:** 836 18th Avenue, Sidney

I Care

- **When:** Monday-Thursday open for scheduling; Doctor in office on Tuesdays
  - By appointment only (308-254-0202)
- **Where:** 1135 Jackson Street, Sidney

Sidney Vision Clinic

- **When:** Monday, Tuesday, Thursday, or Friday
  - By appointment only (308-254-4041)
- **Where:** 900 Pine Street, Sidney

Webb Eyecare

- **When:** Monday-Thursday
  - By appointment only (308-262-1252)
- **Where:** 921 Main Street, Bridgeport

GET READY FOR KINDERGARTEN

AND TAKE ADVANTAGE OF THESE KINDERGARTEN DENTAL EXAM SPECIALS

DENTAL SCREENING: Why? A dental screening by a qualified dentist or dental hygienist is **required prior to Kindergarten.** A parent or guardian who objects may submit a written statement of refusal for his or her child. Waiver forms are available in the school office.

All clinics offer a free screening/exam. Any additional services needed (cleaning, fluoride, treatments, etc.) will require another appointment date and you will need to discuss cost and payment options with the clinic.

High Plains Dental

- **When:** Monday-Thursday
  - By appointment only (308-254-2065) - at time of appointment scheduling, please inform the office that this is a Kindergarten exam
- **Where:** 1545 10th Avenue, Sidney

LifeSmiles of Sidney

- **When:** Monday-Thursday
  - By appointment only (308-254-7171) - at time of appointment, please inform the office that this is a Kindergarten exam.
- **Where:** 1040 Old Post Road, Sidney

Chappell Family Dentistry

- **When:** Monday-Thursday
  - By appointment only (308-874-2910) - at time of appointment, please inform the office that this is a Kindergarten exam.
- **Where:** 246 Vincent Ave, Chappell

Bridgeport Family Dental

- **When:** Monday-Thursday
  - By appointment only (308-262-1434) - at time of scheduling, please inform the office that this is a Kindergarten exam.
- **Where:** 1006 Main Street, Bridgeport

Nebraska School Immunization Rules and Regulations For Students Entering Kindergarten

Nebraska School Rules and Regulations for immunizations are available on the internet: http://dhhs.ne.gov/Pages/School-Immunization.aspx

- Tetanus-diphtheria (DTaP, DTP, DT or Td) - 3 doses, one given after the 4th birthday.
- Polio - 3 doses needed.
- Hepatitis B series - all 3 doses of the series needed.
- Measles (MMR or MMRV) - 2 doses to be given on or after 12 months of age, and separated by at least one month.
- Varicella (chickenpox) - 2 doses to be given on or after 12 months of age or Documentation of having the disease

Immunization clinics in our area are: to save yourself a trip, schedule your child's physical at the same time!

Morrill County Hospital Clinic
- Monday-Friday
- 8-5
- Call 308-262-1755 to schedule an appointment.

Sidney Regional Physicians Clinic
- Monday-Friday
- 8-5
- Call 308-254-5544 to schedule an appointment.

Regional West Dorwart Family Medicine
- Monday-Friday
- 8-5
- Call 308-254-9192 to schedule an appointment.

Did you know...

You can view and print your child's immunization records in the NESIIS system (Nebraska State Immunization Information System) at http://www.dhhs.ne.gov/nesiis

- From the home page, scroll down and click on "check your immunization records".
- This will take you to another screen where you will enter your child's name, birthdate and SS#.
- Click "search" and your child's immunization records will appear on the screen.
- From here, you can view and print your child's immunizations.

NESIIS electronically stores a child's immunization record in a secure system. You and your Health Care providers can access the information to determine which, if any, immunizations are needed at any given time. Complete and up to date immunization records can be printed for yourself, schools, daycares, or whenever you need them.

Dear Kindergarten Parents:

Attached are the forms needed for all kindergarten students to begin the school year. In addition to these forms, the following items are also needed:

Copy of his/her state issued birth certificate

Copy of his/her social security card

Copy of his/her up to date immunization records

If you bring in originals, we will be happy to make copies for you. Thank you.

Enrollment Form for Leyton Elementary\Jr. High

First Name:	Middle:	Last Name:
Preferred Name:	Grade:	Birth Place: / DOB:

Race: Amer. Indian or Alaska Native   Asian   Black or African American   Native Hawaiian/Pac Islander   White   *(underline)*

Hispanic/Latino? Yes No (underline one)	Gender:	Home Lang.:
Access Internet?	Cell #	Email:

PRIMARY HOUSEHOLD (STUDENT RESIDES AT)

Mailing:			Street:		
City:	State:	Zip:	City:	State:	Zip:

Information for adults living at the above address.

Name:	Relationship:	Employer:	
Work #	Cell #	POL Account:	Receive Printed Mailings:
Email:	Wk Email:	Home #	
Name:	Relationship:	Employer:	
Work #	Cell #	POL Account:	Receive Printed Mailings:
Email:	Wk Email:	Home #	

ALTERNATE HOUSEHOLD (NON CUSTODIAL)

Mailing:			Street:		
City:	State:	Zip:	City:	State:	Zip:

Information for adults living at the above address.

Name:	Relationship:	Employer:	
Work #	Cell #	POL Account:	Receive Printed Mailings:
Email:	Wk Email:	Home #	
Name:	Relationship:	Employer:	
Work #	Cell #	POL Account:	Receive Printed Mailings:
Email:	Wk Email:	Home #	

ALTERNATE HOUSEHOLD (NON CUSTODIAL)

Mailing:			Street:		
City:	State:	Zip:	City:	State:	Zip:

Information for adults living at the above address.

Name:	Relationship:	Employer:	
Work #	Cell #	POL Account:	Receive Printed Mailings:
Email:	Wk Email:	Home #	
Name:	Relationship:	Employer:	
Work #	Cell #	POL Account:	Receive Printed Mailings:
Email:	Wk Email:	Home #	

EMERGENCY CONTACTS: Enter additional contacts not listed above.

Name:	Relationship:	Email:
Home #	Work #	Cell #
Name:	Relationship:	Email:
Home #	Work #	Cell #
Name:	Relationship:	Email:
Home #	Work #	Cell #

Emergency Medical Information

Physician:	Phone:	Hospital:

Medical Notes:

Daycare Information (if applicable)

Provider:	Phone:

SIBLINGS (other students living at same address)

First Name	Middle Name	Last Name	Grade	Birthdate	School Name

Completed By: ____________________ Signature: ____________________ Date: ____________

Leyton Public School District

Home Language Survey

School:____

When new students enter Nebraska schools, a Home Language Survey must be completed to determine if the student is a potential English Learner. Thank you for completing this brief questionnaire.

Child Name:____________________________________D.O. B.____________

Question	Answer
1. What language did the student first learn to speak?	
2. What language is spoken most often by the student?	
3. What language is primarily used in the student's home regardless of the language spoken by the student?	

Parent/Guardian Signature:______________________________________

Date:____

Leyton Public Schools

Student Health Information

The following information is considered confidential and is for the use of teachers, principal, school nurse/health staff, or other staff who will be in contact with and responsible for your child during the school day.

____

Student Name　　　　Birthdate　　　　Grade

____

Signature of Parent/Guardian　　　　Printed name/relationship to student　　　　Date

_______________________　　　　_______________________

Home Phone　　　　Work Phone

CHECK ANY OF THESE CONDITIONS WHICH YOUR CHILD HAS:

____Cancer　____Kidney/ Bladder Disease　____Vision Problems　____ADD
____Diabetes　____Convulsions, Seizures　____Hearing Problems　____ADHD
____Heart Disease　____Orthopedic/Bone　____Social/Emotional/Behavioral Issues
____Autism　____Bowel/Bladder Issues　____In Counseling
____Asthma　Provoked by:______________________________ Severe ____Yes　____No

If yes, please obtain Asthma/allergy action plan from the school secretary.

____Allergy to ______________________________________ Severe ____Yes　____No

Has the above condition been diagnosed by a medical doctor? ____Yes ____No
If yes, what is the doctor's name?____________________________ Phone # ______________
May we obtain this information? ____Yes ____No

If yes, please sign a release of information obtained from the school secretary.

What does your child do to manage his/her condition?

____

____

How can the teacher help with this at school?

____

____

What symptoms should we report to you?

____

____

Takes medication daily at ____ home ____school
Medication is: ____
For:____

If your child must receive medication while at school, an "authorization for medication" form must be completed and signed by parents or legal guardians of the child. If it is for a prescription medication, your child's doctor must sign the form. (chapter 195-182) You can obtain this form from the school secretary.

Provide any information not included above which you think we should know about your child's physical, mental, or emotional health which might affect school performance or require special consideration, ie. Limitations in activities etc.

____

____

____

SCHOOL HEALTH SCREENING

****

_______ I do **NOT** wish to have my child screened at the school.

By making this selection, the parent or guardian will be responsible for a Physician's screening within the last 6 months. <u>This form is due back to the school office prior to admission.</u>
The following information is required:

Height_______ Weight_______ Hearing Screening_______ Distance Vision_______ Dental________

Physician's Signature____ Date_______________

Student Name______________________________ Grade______

Parent/Guardian Signature_____________________________________ Date_______________

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Nebraska Department of Health & Human Services

Physical Exam Report

Immunizations received today:
__ DTaP __ Hep A __ Hep B __ HPV
__ Meningococcal __MMR __ Polio __ Td
__ Tdap __ Varicella
__ Other (specify):

Chronic Conditions:
__ ADD/ADHD
__ Asthma
__ Autism/Asperger's
__ Diabetes Type I, Type II
__ Other:
__ Allergies: ____________________
__ Medications: ____________________

__ History of Concussions:

Results of any lab work done:

Audiometric Screening					
	500	1000	2000	4000	6000
Right					
Left					

Vision Evaluation	PASS	FAIL	Further eval needed
Amblyopia			
Strabismus			
Internal Eye Health			
External Eye Health			
Visual Acuity			Correction
20 feet	Right	20/	Yes/No
	Left	20/	Yes/No
16 inches	Right	20/	Yes/No
	Left	20/	Yes/No
Date of Vision Evaluation			
Signature			

NRS 79-214 requires evidence of a physical exam by an MD, PA or APRN within 6 months prior to entrance into Kindergarten, 7th Grade or an out of state transfer student. Vision evaluation is required for within 6 months prior to entrance into Kindergarten or an out of state transfer student. The cost of such physical exam and visual evaluation shall be borne by the parent or guardian of each child who is examined.

Student Name ____________________
Date of Birth ______________ **Grade** _____
By signing below, the parent/guardian of the above named student consents for the release of the health and medical information contained herein to be released to

Leyton Public Schools
(Name of School)

____
(Signature of Parent/Guardian)

Height:	Weight
BMI:	BMI Percentile:
Blood Pressure:	Pulse:

Physical Findings:	Normal	Abnormal
Appearance		
Ears/Eyes/Nose/Throat		
Lymph nodes		
Heart (note murmur if present)		
Pulses		
Lungs		
Abdomen		
Skin		
Musculoskeletal		
Neck		
Spine/Scoliosis		

__ Cleared for participation without restrictions

__ Cleared after completing evaluation and/or rehabilitation for:

____

__ Not cleared for: ____________________
Reason: ____________________
Recommendations: ____________________
____
____
(Address)
Phone: ____________ Date: ____________

____
(Signature of Medical Provider)

Department of Health and Human Services
Report of Visual Evaluation

School Name (if desired) Leyton Public Schools

Effective with the 2006-07 school year, Nebraska State Statute 79-214 requires students entering kindergarten (or first grade, if not enrolled in kindergarten) to provide evidence of visual evaluation within six months prior to entry. This requirement also applies to out-of-state transfers to any grade. The vision evaluation may be performed by a physician, physician assistant, advanced practice nurse practitioner, or vision professional (optometrist or ophthalmologist). Students are exempt from this requirement when the parent/guardian provides a written statement of objection. For more information about the vision evaluation requirement, including the availability of resources for low-income families, please contact the school.

PARENT/GUARDIAN: This form is provided as a convenience to you and your child's health care provider in meeting the requirement for visual evaluation in Nebraska schools. No specific form is required by the statute. The information provided here may be shared with school personnel as needed to promote your child's safety and educational success.

By signing below, the parent/guardian of ____________ **consents for the**
Name of Student

release of the health and medical information contained herein to be released to Leyton Public Schools
Name of School

Signature ____________ Printed Name/Relationship to Student ____________ Date ____________

Student Name ____________ Student ID# ____________

School Leyton Public Schools

Visual Evaluation Report	PASS	FAIL	Recommend Further Evaluation
Amblyopia	☐	☐	☐
Strabismus	☐	☐	☐
Internal Eye Health	☐	☐	☐
External Eye Health	☐	☐	☐
Visual Acuity	☐	☐	☐

20 feet: Right 20/____ Left 20/____ with/without glasses

16 inches: Right 20/____ Left 20/____ with/without glasses

Comments:

Signature of Examiner ____________ Date of Exam ____________

Name/Title of Examiner (please print or use stamp) ____________

Leyton Public Schools

DENTAL EXAM KINDERGARTEN ONLY

____

Student Name Birthdate Grade

By signing below, the parent/guardian of ______________________
consents for the release of the health and medical information contained herein to be released to Leyton Public Schools.

____

Signature of Parent/Guardian Printed name/relationship to student Date

Dental Health

Caries: ______________________________________

Hygiene: ______________________________________

Comments: ______________________________________

____

****

____

Signature of Examiner Date of Exam

____

Name/Title of Examiner (please print or use stamp)