NORTH NEWTON SCHOOL CORPORATION

KINDERGARTEN INFORMATION

FOR

2018-2019 SCHOOL YEAR

IMPORTANT INFORMATION

The following is a list of requirements for Kindergarten Students:

-Must be five (5) years of age on or before August 1st

-Legal birth certificate (not hospital certificate)

-Documented evidence of immunizations:

(5) DPT/TD (4) Polio (2) MMR (2) Hepatitis A Vaccine (3) Hepatitis B Vaccine (2) Varicella Vaccine OR schedule of when immunizations will be given

The following is a list of requirements that will need to be turned in by the first day of school:

-Physical Examination (a doctor's printed out report is also acceptable)

-Dental Examination (recommended, not required)

- Eye Examination (recommended, not required)

-Custodial papers, if not living with both natural parents

PHYSICAL/DENTAL/VISION FORMS ARE INCLUDED BELOW

North Newton School Corporation Kindergarten Physical Form

Student Name:_____

Physical Exam Requirements

	Normal	Comments
Skin		
Ears		
Eyes		
Throat		
Mouth/dental		
Cardiovascular		
Respiratory		
Endocrine		
Gastrointestinal		
Genito-urinary		
Neurological		
Musculoskeletal		
Spinal exam		
Height		
Weight		
Blood pressure		
Heart rate		
Any restrictions		

Physicians Signature:_____

Printed Physician Name:_____ Date:_____

Address & Phone Number:_____

Immunizations

Vaccine	Date/dose 1	Date/dose 2	Date/dose 3	Date/dose 4	Date/dose 5
Dtap,DTP,DT					
IPV					
MMR					
Hep B					
Varicella					
HIB					
Pneumococcal					
Hep A					
Other					

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Dental Examination Form

Student's Name_____School_____

Parent's Name_____Phone_____

Address_____

Significant Medical History_____

_____

Dental Exam:

Soft Tissue_____ Oral Hygiene_____

Occlusion_____ Evidence of Dental Care_____

Comments_____

_____

Restorative Care Indicated: Yes_____ No_____

Appointments Scheduled: Yes_____ No_____

Dentist Name_____

Address_____

Phone Number_____ Date_____

Dentist Signature_____

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School Vision Examination

Visual status of your child's eyes should be known. It is recommended that checkup be done by your eye doctor.

Name of Student_____School_____

Eye Examination: (to be filled out by eye doctor)

Visual Acuity: Right Eye_____ Left Eye_____

Muscle Balance: Distant _____

Near_____

Refractive State: Right Eye_____

Left Eye_____

External Eye Inspection:_____

Internal Eye Inspection:_____

Comments:_____

_____

Another eye exam is recommended:_____

Name of Eye Doctor_____

Address_____

Phone Number_____Date_____

Signature_____