firsthand
HEALTHE KIDS SCREENINGS

www.firsthandfoundation.org/healthekidsscreenings

July 1, 2017

Dear Parents or Guardians,

Our school is excited to offer **free**, comprehensive health screenings. The health of children is strongly linked to their academic success. Our school is pleased to partner with First Hand Foundation's Healthe Kids Screenings program to ensure your student is healthy and able to reach their full learning potential.

Academie Lafayette Oak is hosting screenings on November 6-7, 2017.

A professionally trained and experienced team, including Registered Nurses, will provide the following screenings:

- Temperature, height, weight, waist circumference and BMI percentile
- Vital signs (blood pressure, heart rate and respiratory rate)
- Vision (near and far)
- Hearing
- Head-to-toe screening (eyes, ears, nose, throat, teeth, neck, heart, lungs, stomach, reflexes, spine, skin and balance)

Why this is important for your child?

- Even for children who receive a yearly well-child exam, a child's health can change as they grow.
- Near vision and hearing screenings are typically not provided during an annual physical.
- Screenings are convenient—held during the school day and parental attendance is not required.
- At the completion of the screening, each participating child receives a goody bag, including a toothbrush and toothpaste.
- Healthe Kids Screenings supports the connection between your child's physical health and their education.

You will receive the results of the screening in a sealed envelope that will be sent home from school with your child. If a potential health issue is identified for your child, the letter will include a recommendation for further evaluation.

Parental permission is mandatory - please complete the attached forms and return them to me no later than October 23, 2017.

However, if this date has passed and the screenings have not yet been conducted, please return these forms and every attempt will be made to screen your child.

If you have any questions, please feel free to contact me at 816-361-7735.

Sincerely,

School Health Room

FOR OFFICE USE ONLY
Date Scheduled: _____
Time: _____ Slot #: _____
Verified: _____

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FOR OFFICE USE ONLY
Registered: ___ Scheduled: ___
Medical history: _____
Scanned: _____

I, _____ , the parent or legal guardian of _____ (child's name), agree to allow him/her to participate in a voluntary health screening including height, weight, waist circumference, temperature, BMI, blood pressure, respiratory rate, heart rate, vision, hearing and a physical screening (including eyes, ears, nose, throat, teeth, neck, heart, lungs, stomach, reflexes, spine, skin and balance; with clothes on) and is being sponsored by the Healthe Kids Institute ("Healthe Kids Screenings") at my child's school ("school"). I understand that my child's relationship with the Healthe Kids Screenings team will be limited to the scope and duration of the health screening and will not constitute a provider-patient or other long-term relationship. If my child needs immediate medical attention, Healthe Kids Screenings will notify the school's health room in compliance with school policy.

I understand that this program is a screening, not a diagnosis; if Healthe Kids Screenings identifies a referral issue, my child may need further evaluation from his/her primary care provider. Following the completion of the health screening, a form with the summary of results will be sent home with my child in a sealed envelope. A subsequent communication may be sent home with my child several weeks after the screening date if a referral issue is identified. The school's health room may contact me to discuss any further evaluation pertaining to my child's referral issue(s). Healthe Kids Screenings may, working with the school, rescreen my child at a later date if a referral issue was identified during the initial screening.

I understand that Healthe Kids Screenings works closely with the First Hand Foundation which has a program to provide financial assistance for a child's medical care expenses if the child meets the pre-established criteria. I give permission for the school to contact the First Hand Foundation if my child meets the criteria and my family requires financial assistance for the referral issue(s).

Screening results, along with any other information provided by me or the school's personnel will be documented in a secure, web-accessible health record. I give permission to Healthe Kids Screenings to allow the school to access and make documentations in my child's secure, web-accessible health record.

I GIVE HEALTHE KIDS SCREENINGS PERMISSION TO USE MY CHILD'S DE-IDENTIFIED DATA-DATA FROM WHICH ALL PERSONALLY IDENTIFIABLE INFORMATION HAS BEEN REMOVED-TO ANALYZE TRENDS AND CREATE REPORTS FOR RESEARCH, PUBLICATIONS AND OTHER HEALTH PURPOSES.

Except as outlined in this authorization, my child's health record will be kept confidential.

By signing below, I affirm that I have read, understand and agree to the contents of this form. I agree that this authorization shall be valid until rescinded in writing or replaced by a subsequent form signed on a later date. This consent is valid for up to one year. I understand I may revoke or withdraw this consent at any time prior to the screening.

Child's name

Printed name of parent/legal guardian

Child's date of birth (Month, Day, Year)

Signature of parent/legal guardian

Child's gender (circle one): Male Female

Parent/legal guardian's relationship to child

Teacher's name Child's grade

Date signed

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DEMOGRAPHICS AND HEALTH HISTORY: A.L. OAK

Please return the completed form to your school's health room.

Child's name (First, Middle and Last): _____

Child information

1. Gender: ☐ Male ☐ Female
2. Birth date: ____/____/____ Age: _____
3. Primary language spoken at home:
   ☐ English ☐ Spanish ☐ Other: _____
4. Race (please check all that apply):
   ☐ Asian
   ☐ Black or African American
   ☐ Hispanic
   ☐ Native Hawaiian or Other Pacific Islander
   ☐ White
   ☐ Other: _____
5. Child's Zip Code: _____
6. Primary phone number: (____) _____

Child's primary care physician information

☐ ***No primary care provider***
☐ Baby and Child Associates
☐ Children's Mercy Primary Care Clinic
☐ Cockerell and McIntosh
☐ Independence Pediatrics
☐ Lee's Summit Physician's Group
☐ Preferred Pediatrics
☐ Swope Health
☐ Tenney Pediatrics
☐ Other: _____ Phone number: (____) _____

Child's insurance information

☐ ***No insurance coverage*** ☐ Medicaid (Kansas)
☐ Commercial/private ☐ Medicaid (Missouri)

Child's medical information

1. Date of your child's last dental exam: ____/____/____
2. Does your child have any of the following medical conditions:
   ☐ ADHD ☐ Diabetes ☐ Heart problems
   ☐ Asthma ☐ Heart murmur ☐ Seizure disorder
   ☐ Autism ☐ Other: _____
3. If your child has had any surgeries, please check all that apply:
   ☐ Placement of ear tubes
   ☐ Removal of tonsils/adenoids
   ☐ Hernia repair
   ☐ Correction of bone fractures
   ☐ Eye muscle repair
   ☐ Other: _____
4. If your child has ever been hospitalized, please provide the causes:
   Cause: _____
   Cause: _____
   Cause: _____

Child's allergies

☐ None ☐ Milk ☐ Shellfish
☐ Egg ☐ Peanut ☐ Wheat
☐ Other: _____

Child's medications

☐ Adderall (Amphetamine and Dextroamphetamine)
☐ Albuterol
☐ Flovent
☐ Nasonex (Mometasone)
☐ QVAR
☐ Ritalin (Methylphenidate Hydrochloride)
☐ Singulair (Montelukast)
☐ Zyrtec (Cetirizine)
☐ Other: _____

Child's lead risk information

******Complete only if your child is UNDER AGE 6******

If your child has ever received a lead test, what were the results?
☐ Positive ☐ Negative ☐ Unknown

Does your child:
☐ Live in/regularly visit a daycare or house built before 1950
☐ Live in/regularly visit a house built before 1978 that has chipping paint/has been remodeled within the past 6 months
☐ Live with someone who works with or has hobbies that use lead
☐ Have playmates with lead poisoning
☐ Eat non-food items (soil, paint, etc.)
☐ Live near a highway
☐ Use homemade medical remedies or make pottery