Johnston Back To School
HEALTH & RESOURCE CLINIC

Child's Last Name: _____ Child's First Name: _____ DOB ___ / ___ / ___

JOHNSTON School District for 2019-20 School Building: _____ Grade Entering: _____

Language Spoken at Home (other than English): _____

Insurance Status (check one):

**Immunizations are available at the clinic to those that have Medicaid, American Indian/Alaska native, are underinsured or have no insurance.*

☐ No Insurance ☐ Underinsured ☐ Medicaid ☐ American Indian/Alaska Native ☐ Hawk-i ☐ Private Insurance

IMPORTANT STATIONS TO VISIT

Office Staff Only

Check-in Time: _____

Check-out Time: _____

☐ TO DO ☐ DONE

LEAD SCREENING | K

Required for Kindergarten

☑ TO DO ☐ DONE

IMMUNIZATIONS

[REQUIRED STOP] Check current immunizations with Polk Co. Health Dept.

☐ TO DO ☐ DONE

PRE-PHYSICAL

Height, Weight, Vitals

☐ TO DO ☐ DONE

REGULAR PHYSICAL | PK, K, 3

Required for Pre-K, Kindergarten and 3rd grade. Recommended for 6th grade.

☐ TO DO ☐ DONE

SPORTS PHYSICAL | 8-12

Required for grades 8-12 participating in school athletics

☐ TO DO ☐ DONE

DENTAL EXAMS | K & 9

Required for Kindergarten and 9th grade

☐ TO DO ☐ DONE

VISION SCREENING | K & 3

Required for Kindergarten and 3rd grade

☐ TO DO ☐ DONE

VISION SCREENING | PK

Lion's Club offering for ages 6 months through 5 years

☑ TO DO ☐ DONE

SCHOOL REGISTRATION | K-12

[REQUIRED FOR ALL K-12 STUDENTS] Infinite Campus

☑ TO DO ☐ DONE

CHECK-OUT

[REQUIRED LAST STOP] Get ticket for backpack/supplies

Johnston Community Education

Johnston Partnership

Johnston Community School District

FIND ADDITIONAL STATIONS ON THE MAP

PLEASE COMPLETE ONE FEEDBACK FORM PER FAMILY BEFORE CHECKING OUT

COUNTY OF POLK
Health Department
www.polkcountyiowa.gov/health

Helen Eddy, Director
1907 Carpenter Avenue
Des Moines, Iowa 50314
Ph. 515.286.3798
Fax. 515.286.2033

Release of Medical Information Form

I hereby authorize Polk County Health Department to release all medical information for my child _____ to the doctor and/or clinic identified below. This authorization is effective for records related to this event only.

_____
Signature of parent or guardian of student

_____ _____
Relationship to the student Date

_____
Name of Provider

_____
Name of Clinic

_____
Phone 1

_____
Phone 2