



2700 KEARNS BOULEVARD
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KINDERGARTEN REGISTRATION HEALTH INFORMATION

1. Utah State Law (53A-11-302) requires that every student have a current and completed Pink Utah School Immunization Record. **You will need to bring a copy of your child's current immunization record to your child's school for verification by the school secretary.**

The **Summit County Health Department** provides immunizations for those who have Medicaid, CHIP, or who do not have insurance coverage. If this applies to you, please call 615-3910.

These are the current required immunizations for Kindergarten entry are:

- 5 DTP/DT/DtaP (4 doses if the 4th dose given on/after the 4th birthday)
- 4 Polio/IPV (3 doses if the 3rd dose given on/after the 4th birthday)
- 2 MMR (the 1st does must be given on/after the 1st birthday)
- 3 Hepatitis B
- 1 Varicella (or parent verification of child having chickenpox disease)
- 2 Hepatitis A

Exemptions are accepted but must be obtained at the **Summit County Health Department** and hand delivered to the school. Any student on exemption status may be held from school if an outbreak of the exempted vaccine-preventable disease occurs.

2. A pre-vision screening is required by Utah State Law (53A-11-203-1a) for all Kindergarten students. This can be done by your child's health care provider and is normally done at the 5-year-old well checks. **It is required that you present the school with a signed *Vision Screen Certificate*. The bottom of this page includes a form you may take to your health care provider for verification of this required vision screening. Exemptions are allowed with a written statement by parent or legal guardian stating that vision screening violated personal belief.**

If you have any questions about these health requirements, please contact your school nurse.

PPES, TSES, EHIMS	Anne Alexander, R.N.	615-4429
TMIS, PCHS, PCLC	Gina Agy, R.N.	645-5628, ext. 2922
JRES, MPES	Kirsten Brotherson, R.N.	645-5600, ext. 2924

*The box below must be completed by your Health Care Provider before your child starts school. Please submit this form with your Kindergarten Registration.

PARK CITY SCHOOL DISTRICT VISION SCREEN CERTIFICATE

STUDENT NAME: _____

DATE OF SCREENING: _____ **PASSED:** _____ **REFERRED:** _____

HEALTHCARE PROVIDER SIGNATURE: _____

A written statement signed by a parent or legal guardian that the vision screening violated the personal beliefs is acceptable in place the screening.