# Towns County Elementary School

## Documents Needed to Register

Immunization Record Form 3231
(If out of state-has to be converted to a GA form)

Hearing, Vision, Dental (HVD) Screening Form 3300
(If entering a GA school for the first time)

Certified Copy Birth Certificate

Social Security Card

Proof of Resident of Towns County
(Ex. Water, electric or phone bill)

*Principal:*
Dr. Sandra T. Page
Email: sandrapage@townscountyschools.org

*System Web Address:*
www.towns.k12.ga.us

TOWNS COUNTY ELEMENTARY SCHOOL
STUDENTS REACHING THEIR HIGHEST POTENTIAL

*Assistant Principal:*
Mrs. Stephanie Moss
Email: stephaniemoss@townscountyschools.org

*Counselor:*
Sabrina King
sking@townscountyschools.org

# Immunization Requirements for Towns County Schools

All children entering Towns County Schools are required to meet the following:

New** A Hearing, Vision, Dental and Nutrition Screening must also be completed on Georgia Form 3300. All immunizations are required to be on Georgia Form 3231 and must be current in order for your child to be enrolled in Towns County Schools.

1. Have the required doses of Hepatitis B, Diphtheria, Tetanus, and Pertussis (DTP) and polio vaccines.
2. Have two doses of Mumps, Measles, and Rubella (MMR) or two doses of Measles vaccine, two doses of Mumps vaccine, and one dose of Rubella vaccine or laboratory proof of immunity against Measles, Mumps or Rubella. If child is under four, at least one dose is required.
3. Have two doses of Varicella (chicken pox) vaccine or documentation of disease or laboratory proof of immunity. If child is under four, at least one dose is required.
4. If your child is under five years of age, he must have protection against pneumococcal disease. He will need the Pneumococcal Conjugate vaccine (PCV). The number of doses needed will depend on the child's age. Your child must have at least three doses of HIB.
5. If your child was born on or after January 1, 2006, he must have two doses of Hepatitis A (Hep A) vaccine or laboratory proof of immunity. The first dose must be given on or after the first birthday with spacing of six months or greater between doses.
6. If your child was born on or after January 1, 2006, he must have at least four doses of Polio (OPV and/or IPV). The final dose must be given on or after the fourth birthday and must be at least six months from the third dose.
7. For students entering from out of state schools, please contact the Georgia Health Department or a Georgia licensed physician to have immunizations transferred to the Georgia Certificate Form 3231.

Georgia Department of Public Health

# Georgia Department of Public Health
# Form 3300
## Certificate of Vision, Hearing, Dental, and Nutrition Screening

*PLEASE SEE THE INSTRUCTIONS ON THE BACK OF THIS FORM*

FILE THIS FORM WITH THE SCHOOL WHEN YOUR CHILD IS FIRST ENROLLED IN A GEORGIA PUBLIC SCHOOL
SCREENER CONTACT INFORMATION IS REQUIRED

**Parent/ Guardian Name:** _____
first middle last

**Parent/ Guardian Contact Information:**

Daytime phone number: _____

Evening phone number: _____

Cell phone number: _____

**Child's Name:** _____
first middle last

**Date of Birth:** ____/____/____ **Gender:** ☐Male ☐Female

**Child's Home Address:**

_____
street city state zip code county

### VISION
☐ Unable to screen (explain why below)
☐ Uses corrective lenses
☐ Worn for testing

☐ Passed (20/30 in each eye for age 6 and above, 20/40 in each eye for below age 6)
☐ Needs further evaluation
☐ Under professional care (explain below)

**Screening completed by:**
☐ Physician
☐ Local Health Department
☐ Optometrist
☐ "Prevent Blindness Georgia" employee
☐ School Registered Nurse

_____
**Screener's Signature** **Date**
*I certify that this child has received the above screening.*
**Contact Information:**

### HEARING
☐ Unable to screen (explain why below)
☐ Uses hearing aid / assistive device

☐ Passed at 500, 1000, 2000, and 4000 Hz with audiometer at 20 or 25 dB
☐ Needs further evaluation
☐ Under professional care (explain below)

**Screening completed by:**
☐ Physician
☐ Local Health Department
☐ Audiologist
☐ Speech-Language Pathologist
☐ School Registered Nurse

_____
**Screener's Signature** **Date**
*I certify that this child has received the above screening.*
**Contact Information:**

### DENTAL
☐ Unable to screen (explain why below)

☐ Normal appearance
☐ Needs further evaluation
☐ Emergency problem observed
☐ Under professional care (explain below)

**Screening completed by:**
☐ Physician
☐ Dentist
☐ Local Health Department Registered Nurse
☐ Registered Dental Hygienist
☐ School Registered Nurse

_____
**Screener's Signature** **Date**
*I certify that this child has received the above screening.*
**Contact Information:**

### NUTRITION
☐ Unable to screen (explain why below)

Height: _____ Weight: _____
BMI: _____ BMI%: _____

☐ 5th to 84th percentile - Appropriate for age
☐ < 5th percentile - Needs further evaluation
☐ ≥ 85th percentile - Needs further evaluation
☐ Under professional care (explain below)

**Screening completed by:**
☐ Physician
☐ Local Health Department
☐ Registered Dietician
☐ School Registered Nurse

_____
**Screener's Signature** **Date**
*I certify that this child has received the above screening.*
**Contact Information:**

**FOR SCHOOL SYSTEM ONLY** Follow up for further evaluation

| | 1st attempt | 2nd attempt | Actions reported (if any) |
|---|---|---|---|
| Vision | | | |
| Hearing | | | |
| Dental | | | |
| Nutrition | | | |

Student support services initiated on:

**Screeners' Comments:**

DPH Form 3300 Rev. 2013