Catalina Foothills School District

Health Information / Emergency Form ccccccccccccc

Student's Name: _____
(Last Name) (First Name)

Birth date:_____ Sex: F M Teacher:_____ Grade:_____

Address: _____

Mother's Name: _____
Home Phone: _____
Work Phone:_____
Cellular_____
EMAIL: _____

Father's Name:_____
Home Phone: _____
Work Phone: _____
Cellular_____
EMAIL: _____

Student lives with: Both Parents ____ Mother _____ Father _____ Other (please indicate)_____
Please explain custody arrangements if applicable
_____
Persons who will pick up and care for the student if parents cannot be reached:
Name:_____ Phone:_____ Relationship:_____

Name:_____ Phone:_____ Relationship:_____

Doctor's Name:_____ Phone _____

Does the student have any of the following:

Glasses/Contacts _____ Color Vision Deficiency _____ Hearing problems / aids _____
Assistive devices _____

In case of emergency, our procedure will be to contact the parent. If we are unable to reach the parent, the seriousness of the problem will dictate the course of action to be taken:

1. The person you designate may be asked to care for your child.
2. In accordance with district policy, the school nurse, principal, or authorized designee shall call an emergency medical service if it appears hospital treatment may be required. In the event the paramedics are called and emergency transportation is advised, the individual patient shall be responsible for the cost.

Do you give your consent for your child to be taken to the closest hospital by ambulance if necessary, and emergency care be provided in the event you cannot be reached?

Yes_____ **No**_____ **Hospital Preference:** _____

Do you give your consent to share relevant health information regarding your child with appropriate school / and or emergency personnel as necessary? This would include permission for communication between the health provider and school nurse to facilitate this process.

Yes_____ **No**_____

***PARENT/GUARDIAN SIGNATURE*:**_____ **DATE:**_____

THIS FORM MUST BE SUBMITTED TO THE HEALTH OFFICE BEFORE STUDENT STARTS SCHOOL

Please complete other side. **1 of 2 pages**

STUDENT NAME: _____DATE OF BIRTH: _____GRADE:_____

*** <u>Circle</u> the health concerns/conditions that your child has <u>NOW</u> :** *Add any comments to the Health Problems listed.*

ADD/ADHD:	Headaches/Migraines/Past Concussions (Circle those that apply).
Allergy to foods: List:_____ _____ Does your child need medications at school to treat an allergic reaction YES_____ NO_____ ***If yes, please contact RN and return an Allergy Action Plan to the Health Office with the medications.**	Heart: High Blood Pressure: Liver: Menstrual Cramps: Mild/Severe
Allergy to Medications: List:	Recent Operations/Serious Injuries:
Allergy to insect bites_____ Pollen_____(√ all that apply)	Recurrent Ear Infections;
Anaphylaxis: (to what) _____ (***Contact RN)**	Urinary/Kidney:
Arthritis/Orthopedic:	Emotional/Psychiatric/Depression:
Asthma (***Contact RN):**	
Diabetes (***Contact RN**):	Any other significant conditions or disorders:
Seizure Disorder (***Contact RN):**	

***Forms for student to carry and self-administer Epi-Pen and Inhaler are available on the CFSD website & in the Health Office**

****Please make an appointment with the School Nurse (RN) to discuss any SIGNIFICANT health issues.**

Medications Taken at HOME	Dosage/Frequency	Reason
1.		
2.		
3.		

Parent/Guardian Permission for Over the Counter Medications:

Acetaminophen, (generic Tylenol): an aspirin-free pain reliever can be given for relief of mild headache or pain.
Ibuprofen: for mild to moderate menstrual pain or musculoskeletal pain, for **<u>Middle School and High School students only.</u>**
Tums Tablets, an antacid, can be given for the relief of heartburn, gas, or mildly upset stomach.

Please CIRCLE those medications you give permission for your child to receive through the Health Office:

YES	**NO**	**Acetaminophen (generic Tylenol) 5 yrs of age: 240 mg 6-11 yrs of age: 325 mg 12 + yrs of age: 325 mg - 650mg**		**YES**	**NO**	**Cough Drops**
				YES	**NO**	**Tums Tablet – 2 tablets by mouth**

I hereby authorize the designate of Catalina Foothills School District to be my agent, to give the age appropriate dose of the above named medications as directed to my child. **If there is a Health Assistant in your child's school, a parent will be contacted prior to administration of these medications. If the parent cannot be contacted, the medication will be given at the discretion of the district School Nurse (RN).**

PARENT/GUARDIAN SIGNATURE: ___DATE:_____

SUBMIT TO HEALTH OFFICE BEFORE STUDENT STARTS SCHOOL. ***Please complete other side***

<u>NOTIFY HEALTH OFFICE OF ANY INFORMATION CHANGES IMMEDIATELY. _</u> **2 of 2 pages**

CATALINA FOOTHILLS SCHOOL DISTRICT
HEALTH SERVICES

REQUEST FOR GIVING MEDICATION AT SCHOOL

STUDENT:_____ **GRADE/ TEACHER:** _____

Name of Medication:_____

Dosage: _____

Expiration date: _____

Time to be given:_____

Expected duration of treatment: From_____To_____

Prescriber's Name: _____

Reason for medication:_____

Known Drug or Food Allergy:_____

Parent/Guardian Signature: _____**DATE:**_____

When it is essential to a student's health that medicine (including OTC) be taken during school hours:

- There must be a written order from a licensed Arizona PCP stating the name of the medicine, the dosage and the time it is to be given. Parent consent form must be completed. Medication must be FDA approved.
- The medication must be in the original pharmacy or OTC container.
- Forms for student's to carry and self-administer Epi-pens and Inhalers are available from the health office.
- Parents of Pre K-8th graders must hand deliver prescription medication to the school health office.
- Supervision of medication administration protocol is managed by a Registered Nurse. In the nurse's absence, medication will be administered by an agent/district employee designated by the principal; usually the health assistant or office secretary.

Physician Signature _____Print Physician Name_____

Physician Phone _____Physician Fax _____

***Physician Signature authorizes administration of the above OTC medicine, in the dosage indicated above, by School Nurse or designee.**

Date medication returned to parent	Amount returned	Parent Signature	RN/ HA initials

CATALINA FOOTHILLS SCHOOL DISTRICT
HEALTH SERVICES
ALLERGY ACTION PLAN

Student's Name: _____ D.O.B. _____ Teacher/ Grade_____

ALLERGY TO: _____
If the allergy is to peanuts:
Do you want your child to eat at a Designated Peanut Free Lunch Table? Yes _____ No_____

Asthmatic?

Yes*	No
*** Higher risk for severe reaction**	

STEP 1: TREATMENT
The severity of symptoms can quickly change

LOCATION	SYMPTOMS	ADMINISTER MEDICATION	
	If a food allergen has been ingested, but **NO** symptoms	Epinephrine	Antihistamine
• **Mouth**	Itching, tingling, or swelling of lips tongue, mouth	Epinephrine	Antihistamine
• **Skin**	Hives, itch rash, swelling of the face or extremities	Epinephrine	Antihistamine
• **Gut**	Nausea, abdominal cramps, vomiting, diarrhea	Epinephrine	Antihistamine
• **Throat +** *(+Potentially life-threatening*)	Tightening of throat, hoarseness, hacking cough	Epinephrine	Antihistamine
• **Lung +** *(+Potentially life-threatening)*	Shortness of breath, repetitive coughing, wheezing	Epinephrine	Antihistamine
• **Heart +** *(+Potentially life-threatening)*	Thready pulse, low blood pressure, fainting, "blueness"	Epinephrine	Antihistamine
• **Other +** *(+Potentially life-threatening)*		Epinephrine	Antihistamine
• **If the reaction is progressing** *(+Potentially life-threatening)*	Several of the areas affected	Epinephrine	Antihistamine

EPINEPHRINE: Inject intramuscularly (circle one) EpiPen EpiPen Jr. Twinject 0.3 mg Twinject 0.15 mg.

ANTIHISTAMINE: give _____
Medication/dose/route
OTHER: give _____
medication/dose/route

STEP 2: EMERGENCY CALLS

1) CALL 911, State that an allergic reaction has been treated and additional epinephrine may be needed.

2) Dr._____ at _____

3) Emergency Contacts: Name Relationship Phone Number
A. _____1)_____2)_____

B. _____1)_____2)_____

If the student carries the EpiPen, he/she has been instructed in its use and will report to the Health Office after using. We understand that a **911 call** is required after the EpiPen is administered.

Doctor signature_____ Date: _____
(Required)
Parent signature_____ Date: _____
(Required)

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CATALINA FOOTHILLS SCHOOL DISTRICT
HEALTH SERVICES

PERMISSION TO CARRY INHALER ON CAMPUS

Date: _____ Grade:_____ School Year**:** _____/_____

_____ _____D.O.B._____
(Student's name)

has been instructed in the proper use of

_____
(name of inhaler)

_____
(Parent/legal Guardian Signature) Date

***If there is NO prescription label a PCP signature is necessary**

_____
(Prescriber's Signature) Date

_____
Print Presciber's Name Phone Number