Ganado Unified School District #20

Emergency Health Form

Student's Information

First Name: ___________________________ Last Name: ___________________________ M.I. _____

Date of Birth: ______________________ Gender: ☐ Male ☐ Female

Parent/Legal Guardian Name: _______________________________ Phone Number: _______________

Emergency Contact: ____ Phone Number: _______________

Current Medical Provider / Health Insurance: ____

Student Medical History

ALL INFORMATION IS KEPT CONFIDENTIAL UNDER HIPPAA

Please Check Y (Yes) and N (No) for each condition.

	Y	N		Y	N		Y	N		Y	N
Allergies			Migraines			Blood Pressure			Speech		
Asthma			Cardiac Issues			Frequent UTI			Joint Problems		
Diabetes			Syncope (fainting)			Bowel Issues			Eczema		
Seizures			Cancer			Incontinence			Anemia		
Anxiety			Eating Disorder			Ulcers			Hemophilia		
ADHD			Depression			Hearing Loss			History of Chicken Pox		
Autism			Appendectomy			Vision Impairment			Other:		

Please List Students' Allergies (Food, Medication and other Allergies): ____________________________

____

Are any of the listed allergies Severe or Life Threatening? Please Describe: ________________________

____

Does your child require an EPI-Pen/Inhaler/Prescription Medication during school hours?

____

If YES, please provide a current prescription for medication along with supporting documentation from students Provider/Physician regarding students current condition. Student may not carry medication without those documents.

Medications provided at the Health Office

Draw a line through any of the below medications/creams that **YOU DO NOT** want your child to receive.
The following Over the Counter (OTC) Medications given at School for minor illnesses/ injuries that may occur in school are **LIMITED** to:

**Acetaminophen/Tylenol* **Antibiotic Ointment- For minor cuts/scrapes* **Oragel- For toothaches*

**Cough Drops* ** Irrigating Eye Wash/Eye Drops* **Hydrocortisone Cream- For itching/ Rash*

Continue on the Back →

For the protection of all, students **<u>may not</u>** bring MEDICINE (including Tylenol or any OTC Medications without a prescription) to school!

GUSD Policy JLCD: *Under certain circumstances, when it is necessary for a student to take medicine during school hours, the District will cooperate with the family physician and the parents if the following requirements are met:*

> ***A. There must be a written order from the physician stating the name of the medicine, the dosage, and the time it is to be given.***
>
> ***B. There must be written permission from the parent to allow the school or the student to administer the medicine. Appropriate forms are available from the school office.***
>
> ***C. The medicine must come to the school office in the prescription container or, if it is over-the-counter medication, in the original container with all warnings and directions intact.***

Exceptions:

> ***A. Students who have been diagnosed with anaphylaxis may carry and self-administer emergency medications including auto-injectable epinephrine provided the pupil's name is on the prescription label, on the medication container or device and annual written documentation from the pupil's parent or guardian is provided that authorizes possession and self-administration. The student shall notify the school office secretary as soon as practicable following the use of the medication;***
>
> ***B. For breathing disorders, handheld inhaler devices may be carried for self-administration provided the pupil's name is on the prescription label, on the medication container, or on the handheld inhaler device and annual written documentation from the pupil's parent or guardian is provided that authorizes possession and self-administration.***
>
> ***C. Students with diabetes who have a diabetes medical management plan provided by the student's parent or guardian, signed by a licensed health professional or nurse practitioner as specified by A.R.S. 15-344.01, may carry appropriate medications and monitoring equipment and self-administer the medication.***

If your child requires prescribed medications to be administered during school hours, please provide the Health Office with this information. This should be obtained at the time the medication is prescribed.) Medications must be **brought in by a parent** and **<u>kept in the nurse's office</u>** in the original, pharmacy-labeled container. Medication must be picked up by parent at the end of the school year or it will be discarded.

As the Parent/Legal Guardian of the above named student, I entrust the GUSD's Health Personnel to care and provide for my child's Health/Medical care while in school. **In the event of a medical emergency, I hereby authorize Ganado Unified School District No. 20 to arrange for named doctors or dentist, ambulance/School transportation or hospital facility to provide treatment to my child in case of an emergency, accident or illness.**
I further understand that the School District **does not** carry health insurance for my child.

____ _________________________

Signature of Parent/Legal Guardian Date

Date Received: _____________________________________

Received By: _______________________________________

School Year: _______________________________________