

HEALTH SERVICES REGISTRATION Pre-K - 12

School Year 2019-2020

Student's Name: _____
Last First Middle

Date of Birth: _____ Grade: _____

 Check here if your child **DOES NOT** have any health issues (*sign at bottom*)

Does your child have a life-threatening condition? Yes No

Emergency Care: In case of serious illness or injury and a parent/guardian cannot be reached, I consent for my child to be taken to a hospital, by ambulance if necessary, for medical care. TUSD will not be responsible for any costs of such not covered by insurance.

Parent/guardian is responsible for notifying the school of new or existing health concerns and for providing the school with any medication or equipment that the student will require during the school day. Contact the health office to obtain the correct procedural forms. ***Life-threatening conditions such as anaphylaxis, asthma, diabetes, or other conditions require individual health care plans/actions plans, medication permits, and staff training prior to your child attending.**

My child wears glasses or contacts

ALLERGIES (*requires an Allergy Emergency Plan if intervention is needed at school and a medication permit if medication will be kept in health office)

Food: _____ Bee / Insect: _____ Medication: _____ Environmental: _____ Other: _____

Describe the allergic reaction and the treatment: _____

Injectable Epinephrine prescribed My child will carry Injectable Epinephrine & has been instructed on Epinephrine use

Injectable Epinephrine will be kept in Health Office*

ASTHMA (*requires an Asthma Action Plan if intervention is needed at school and a medication permit if medication will be kept in health office)

Triggers: Exercise Environmental Other: _____

Inhaler prescribed My child will carry inhaler & has been instructed on inhaler use Inhaler will be kept in health office*

My child was diagnosed with asthma but no longer uses an inhaler - date of last asthma episode: _____

DIABETES (*a Diabetes Care Plan is required for all students with Type I Diabetes - please contact the health office staff prior to the start of school)

*Type I (takes insulin) Insulin Pump Pen Syringe Type II Healthcare provider plan

EMOTIONAL/BEHAVIORAL/PSYCHOLOGICAL/DEVELOPMENTAL

ADD/ADHD Anxiety Depression Other Diagnosis(es): _____

Receiving Treatment Yes No

HEARING/VISION (other than glasses or contacts)

Hearing Impairment *Specify:* _____ Visual Impairment *Specify:* _____

MOBILITY/ACTIVITY *Contact health office staff if restriction or assistive device

My child will need help with activities of daily living and/or health care procedures (*contact health office staff)

Activity restriction (*Specify:*) _____ My child uses an assistive device (*Specify:*) _____

SEIZURES (*please contact the health office staff regarding a seizure action plan)

Type of seizure: _____ Date of last seizure: _____

Diastat or other emergency medication at school* Controller medication at home

OTHER MEDICAL ISSUES (if you check any conditions below please explain in space provided)

Cerebral Palsy Heart Condition Concussion (date: _____) Other: _____

MEDICATION

Medications at school _____

If your child requires medication at school, contact the school health office staff. Requires medication permit.

Medication taken at home (*Specify:*) _____

SCHOOL PROVIDED OVER THE COUNTER MEDICATIONS

For students only in 6th – 12th grades:

For minor complaints I authorize the health office staff (*may be unlicensed individuals such as health assistants or office staff*) to give:

Yes No - Acetaminophen <100lbs=325mg, ≥100lbs=650mg (*generic Tylenol for headache, menstrual cramps, or other minor discomfort*)

Yes No - Ibuprofen <100lbs=200mg, ≥100lbs=400mg (*generic Advil for headache, menstrual cramps, or other minor discomfort*)

PERMISSION FOR FLUORIDE MOUTH RINSE PROGRAM TO REDUCE DENTAL CAVITIES

For students only in 1st – 5th grades

I WANT my child to participate in the Arizona Department of Health Services fluoride mouth rinse program. I understand that I can withdraw permission at any time by notifying the school health office in writing.

I DO NOT WANT my child to participate in the Arizona Department of Health Services fluoride mouth rinse program.

I would like more information about dental services available at school. Please contact me

[General Dentistry 4 Kids](https://www.gd4k.com/) <https://www.gd4k.com/>

Insurance

None Yes (Name of Insurance: _____ AHCCCS TriCare)

Information provided on this form will replace and/or update any previous health information received with the exception of Life-Threatening Health Conditions (*contact nurse about removing this information*). It is the parent/guardian responsibility to notify the health office if any changes occur in their child's health status.

Parent/Guardian Name (printed): _____ Parent/Guardian Signature: _____ Date: _____