Maricopa Unified School District
Health Information and Emergency Medical Referral

2018-2019

For School Use
Teacher: ____________________ Grade: ____

LEGAL FIRST NAME	LEGAL MIDDLE	LEGAL LAST NAME	Date of Birth / /	Home Phone

Mailing Address	PO Box	Street Address	City	Zip

Mother/Guardian	Employer	Home Phone
		Work Phone
		Cell Phone

Father/Guardian	Employer	Home Phone
		Work Phone
		Cell Phone

E-Mail Address: ______________________________ **Date:** ______________________________

Current Medical Conditions (Maricopa Unified School District requires a Health Plan to be written for daily and emergency care if your child has a current health problem(s).)**
Does your child currently have any of the following?

Allergies (food, insect stings, grass, etc)	No	Yes – Explain: ____________________	Age: _______________
Asthma	No	Yes – Explain: ____________________	Age: _______________
Diabetes	No	Yes – Type: ____________________	Age: _______________
Heart Condition	No	Yes – Explain: ____________________	Age: _______________
Seizure Disorder	No	Yes – Explain: ____________________	Age: _______________
Cancer	No	Yes – Explain: ____________________	Age: _______________
ADHD	No	Yes – Explain: ____________________	Age: _______________
Other	No	Yes - Explain: ____________________	Age: _______________
Valley Fever	No	Yes – Treatment: _________________	Age: _______________

Does your child have a hearing problem? No Yes – Explain

Does your child wear prescription glasses? No Yes – Explain

Has your child had any surgeries, major accidents or illnesses in the past year? No Yes – Explain

Please specify any chronic health problems:

Does your child have Health Insurance?	Yes	No
May we contact you regarding the School Based Mobile Clinic for our uninsured families?	Yes	No

Are there any other health related issues or past medical conditions that the school needs to be aware of?

Please list <u>all</u> daily medications (Home medication and medication required for school):

____

____

 (continued on back)

Health Care Provider: Primary

Name: ____Phone Number: ___________________

Health care Provider: Specialist

Name: ____ Phone Number: ___________________
Name: ____ Phone Number: ___________________

I agree that health office staff may contact the above mentioned Medical Provider(s) and share medical records and information pertaining to my child's medical history.

Parent Signature: ____________________________________ **Date:** ______________________________

Does your child have an allergy to **Acetaminophen (Tylenol**)? **Yes or No _______ (initial)**

You have permission to give my child **Acetaminophen (Tylenol)** for temperature greater than 100.4, headache, menstrual cramps, dental pain, or injury diagnosed **prior** to arrival of school. I understand that this medication may be administered for only 3 consecutive days without a medical order from my child's health care provider.

Yes or No _______ (initial)

Does your child have an allergy to **Triple Antibiotic Ointment** (Bacitracin, Neomycin, Polymyxin B)?

Yes or No _______ (initial)

You have permission to apply **Triple Antibiotic Ointment** to my child for a small cut (no deeper than 1 ml) or a superficial abrasion. **Yes or No _______ (initial)**

Does your child have an allergy to **Ibuprofen**? **Yes or No _______ (initial)**

You have permission to give my child **Ibuprofen** for temperature greater than 103.0, sever body aches or headache, diagnosed injury prior to arrival of school, severe menstrual cramps, or severe dental pain. I understand that this medication may be administered for only 3 consecutive days without a medical order from my child's health care provider. **Yes or No _______ (initial)**

During a **medical emergency** for a **severe allergy reaction involving a student that does not have a known allergy**, the Maricopa Unified School District Staff may need to administer **Benadryl** and/or an **Epinephrine Injection Pen** to stop the severe allergy reaction while waiting for EMS to arrive. I, the parent of the above mentioned child, give permission for these lifesaving medications during an emergency allergy reaction.

Yes or No _______ (initial)

During a medical emergency involving breathing for a child with known **Asthma**, I give permission for the Health Office Staff to administer nebulized **Albuterol**. **Does not apply** **Yes or No _______ (initial)**

***** In the event of an injury at school, no Tylenol or Ibuprofen will be given until the parent or a medical provider has examined the student. ____________ (parent initial)**

First Aid utilizing Ice, Splinting as indicated, and Elevation to reduce pain will be the treatment provided by Health Services Staff until seen by a health care provider or the parent/legal guardian.

____ ____

Parent/Guardian Signature **Date**

****IMMUNIZATION: NO CHILD will be allowed to register in a Maricopa Unified School District School without a current immunization record or a completed immunization exemption form. Students who qualify within the Federal McKinney-Vento Act parameters may register while in the process of obtaining appropriate documentation. The school registrar and nurse will assist with the process to locate previous immunization records when possible.**