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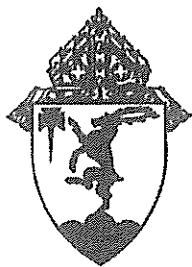
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DIOCESE OF TUCSON CATHOLIC SCHOOLS

Individualized Health Care Plan

School _____ School Year _____

Name of Student _____

Age _____ DOB _____ Grade _____ Date _____

Parents: _____

Phone #s: Home: _____ Work: _____ Cell: _____

In case parents cannot be reached, call _____

at _____. Relationship to student: _____

Medical Provider: _____

Phone: _____ Address: _____

Medical Diagnosis: _____

Medical Instructions: _____

Overall Assessment Data (General assessment of student entering at this time): _____

Conditions Needing Vigilance at School: _____

Instructions: _____

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What the Parents Will Do: _____

What the School Will Do: _____

What the School Will Not Do: _____

What the Child Will Do: _____

Additional Information: _____

List name and title of each person attending this Individual Health Care Plan conference:

NAME

TITLE



CDC/SGH# or name: _____

**Arizona Department of Health Services
Bureau of Child Care Licensing
Emergency, Information and Immunization Record Card**

Child's Name:	Date Enrolled:	Updated:
Home Address (#, Street, City, State, Zip Code):		Date Disenrolled:
Home Phone:	Date of Birth:	Sex: <input type="checkbox"/> male <input type="checkbox"/> female

Mother or Guardian Name:	Home Address (#, Street, City, State, Zip Code):
Cell Phone (optional):	Contact Telephone Number:

Father or Guardian Name:	Home Address (#, Street, City, State, Zip Code):
Cell Phone (optional):	Contact Telephone Number:

**I authorize the following individuals to collect my child from the facility in case of emergency or if I cannot be contacted:
(Pursuant to R9-5-304.B, at least two contact persons are required.)**

Name:	Contact Telephone Number:
Name:	Contact Telephone Number:
Name:	Contact Telephone Number:
Name:	Contact Telephone Number:

If Medical care is necessary, call:

Health Care Provider*	Name:	Contact Telephone Number:
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*A Health Care Provider is a physician, physician assistant or registered nurse practitioner.

In case of injury or sudden illness, I request that this individual be called first:	
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The following individual(s) may NOT remove my child from the facility:

Name(s):

Custody papers have been provided and are on file at the facility. ☐ yes ☐ no

Telephone Authorization Code (optional): _____

Immunization Information

(A licensee shall attach an enrolled child's written immunization record or exemption affidavit to the enrolled child's Emergency, Information and Immunization Record card.)

For information regarding current immunization requirements go to:

www.azdhs.gov/phs/immun/index.htm or contact the Arizona Immunization Program Office at (602)364-3630.

One of these items must accompany the EIIR card at all times:

<input type="checkbox"/>	Copy of current official documented immunization record attached
<input type="checkbox"/>	Religious Beliefs exemption form signed by parent/guardian attached
<input type="checkbox"/>	Medical Exemption form signed by physician and parent/guardian attached
<input type="checkbox"/>	Signed Laboratory Proof of Immunity form attached

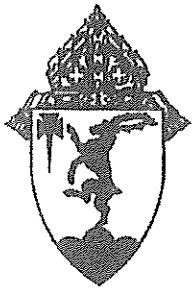
Notification of immunizations needed sent to Parent(s) or Guardian(s):	mo /day/ yr	mo /day/ yr	mo /day /yr
Updated immunizations received and attached:	mo /day/ yr	mo /day/ yr	mo /day /yr

Medical Information

Is child allergic to food or other substances? If yes, describe symptoms, name foods or substances to be avoided, and the procedure to follow if reaction occurs:	<input type="checkbox"/> No <input type="checkbox"/> Yes
Is child usually susceptible to infections and if so, what precautions need to be taken? If yes, list precautions:	<input type="checkbox"/> No <input type="checkbox"/> Yes
Is child subject to convulsions and what should be our procedure if one occurs? If yes, specify procedure:	<input type="checkbox"/> No <input type="checkbox"/> Yes
Is there any physical condition that we should be aware of and what precautions should be taken (heart trouble, foot problem, hearing impairment, hernia, etc.)? If yes, list precautions:	<input type="checkbox"/> No <input type="checkbox"/> Yes
Additional comments:	
Other special instructions:	

This Emergency Information and Immunization Record Card is accurate and complete, front and back, and was provided by:

Parent/Guardian PRINTED Name:	SIGNED Name:	DATE:
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DIOCESE OF TUCSON CATHOLIC SCHOOLS

STUDENT HEALTH FILE RELEASE FORM

School: _____

I, _____, hereby request the release to me
(Printed Name of Parent/Guardian)

of school health records for my child, _____
(Printed Name of Child)

(Signature of Parent/Guardian)

(Date of Request)

**A COPY OF DRIVER'S LICENSE OR OTHER PICTURE ID
FOR ABOVE INDIVIDUAL MUST BE ATTACHED TO THIS FORM.**

HEALTH RECORDS FOR THE ABOVE-NAMED CHILD WERE RELEASED BY:

(Printed Name of Releasing Individual and Title)

(Signature of Releasing Individual)

(Date of Release)

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INSTRUCTIONS FOR RELEASE OF STUDENT HEALTH RECORDS

1. Have the parent/guardian complete the Student Health Record Release Form.
2. Attach a copy of his/her driver's license or other picture ID to the form.
3. Advise him/her that the copies may not be available until later in the day or the next day.
4. Verify with the school Principal (or designee) that there are no legal restraints or injunctions preventing release of personal records on file against the parent or guardian making the request.
5. Make a clear photocopy of the health file folder and all contents.
6. The copies may now be released to the parent/guardian.
7. Place the signed Student Health Record Release Form in the front of the student's health record.
8. Retain the student's original health record on file with the school's other health records or in the archived files, as applicable.



DIocese OF TUCSON CATHOLIC SCHOOLS SPORTS LEAGUE

Physical Form

THIS SECTION TO BE COMPLETED BY PRIMARY CARE PROVIDER

Student's name _____ Sex _____ Gr _____ DOB _____

Father's name _____ Mother's name _____

Physical examination:

Known allergies: _____

Height: _____ Weight _____ BP: _____

Vision: without glasses: B 20/_____ R 20/_____ L 20/_____

Vision: with glasses: B 20/_____ R 20/_____ L 20/_____

Hearing: R _____ L _____

Eyes _____ Glands _____ Skin _____

Ears _____ Heart _____ Nutrition _____

Nose _____ Lungs _____ Speech _____

Teeth _____ Gums _____ Throat _____

Tonsils _____ Hernia _____ Posture _____

Abdomen _____ Orthopedic _____ Scoliosis : Neg: _____ Pos: _____

Urinalysis: _____

Hgb: _____

Cocci: _____ Date: _____ Res: _____

Tbc: _____ Date: _____ Res: _____

Immunizations Given Today:

Is this student currently receiving any medications? _____ List meds: _____

Does this student have any physical conditions or other restrictions which will limit the student's involvement in a regular school program or school activities? _____

I certify that I have on this date examined the above-named student and I have found no medical reason to disqualify him/her from participating in all supervised physical education activities and athletics with the exception: _____

Care provider's comments and/or recommendations: _____

Print care provider's name _____ MD DO PA NP

Care provider's signature _____ Date _____ Phone # _____

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DIOCESE OF TUCSON CATHOLIC SCHOOLS SPORTS LEAGUE

Health History

THIS SECTION TO BE COMPLETED BY PARENT

Today's date _____

Child's Entering Grade _____

Student's Name _____
Last First M.I. DOB _____

Known Medication Allergies _____

Known Food Allergies _____

Has your child ever had any of the following?

Condition	Yes, date	No	Condition	Yes, date	No	Condition	Yes, date	No
Allergies (seasonal)			Hearing Problems			Rheumatic Fever		
Anemia			Heart Problems			Scoliosis		
Asthma			Hepatitis			Seizures		
Back Pain			Hernia			Sinus Problems		
Chicken Pox			Hives			Strep Throat		
Concussion			Joint Pain/Arthritis			Stomach Problems		
Diabetes			Kidney Problems			Tuberculosis		
Eczema			Menstrual Cramps			Valley Fever		
Emotional Problems			Migraine Headaches			Vision Problems		
Fainting			Mononucleosis			Other		

Description	Year	Description	Year
Operations			
Operations			
Sprains			
Fractures			

Does your child wear glasses or contact lenses? _____ Date of last Tetanus Booster _____

If your child is currently under doctor's treatment, please explain and give doctor's name: _____

Medications now taking _____

*If medications are to be given at school, complete "Parent Consent for Giving Medications at School" form.
This must be on file before any medications can be given at school.*

Does this student have any physical conditions or other restrictions which will limit the student's involvement in the school program? _____ Explain _____

Name of Family Physician _____ Phone _____

Parent/Guardian Signature _____ Date _____

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2018-19 ANNUAL PREPARTICIPATION PHYSICAL EVALUATION

(The parent or guardian should fill out this form with assistance from the student-athlete)

Exam Date: _____

Name: _____
Home Address: _____
Phone: _____
Date of Birth: _____
Age: _____
Gender: _____
Grade: _____
School: _____
Sport(s): _____
Personal Physician: _____
Hospital Preference: _____

In case of emergency contact:

Name: _____
Relationship: _____
Phone (Home): _____
Phone (Work): _____
Phone (Cell): _____
Name: _____
Relationship: _____
Phone (Home): _____
Phone (Work): _____
Phone (Cell): _____

Explain "Yes" answers on the following page.
Circle questions you don't know the answers to.

	Y	N
1) Has a doctor ever denied or restricted your participation in sports for any reason?	<input type="checkbox"/>	<input type="checkbox"/>
2) Do you have an ongoing medical conditional (like diabetes or asthma)?	<input type="checkbox"/>	<input type="checkbox"/>
3) Are you currently taking any prescription or nonprescription (over-the-counter) medicines or supplements? (Please specify): _____	<input type="checkbox"/>	<input type="checkbox"/>
4) Do you have allergies to medicines, pollens, foods or stringing insects? (Please specify): _____	<input type="checkbox"/>	<input type="checkbox"/>
5) Does your heart race or skip beats during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
6) Has a doctor ever told you that you have (check all that apply): High Blood Pressure <input type="checkbox"/> A Heart Murmur <input type="checkbox"/> High Cholesterol <input type="checkbox"/> A Heart Infection <input type="checkbox"/>		
7) Have you ever spent the night in a hospital?	<input type="checkbox"/>	<input type="checkbox"/>
8) Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>
9) Have you ever had an injury (sprain, muscle/ligament tear, tendinitis, etc.) that caused you to miss a practice or game? (If yes, check affected area in the box below in question 11)	<input type="checkbox"/>	<input type="checkbox"/>
10) Have you had any broken/fractured bones or dislocated joints? (If yes, check affected area in the box below in question 11)	<input type="checkbox"/>	<input type="checkbox"/>
11) Have you had a bone/joint injury that required X-rays, MRI, CT, surgery, injections, rehabilitation physical therapy, a brace, a cast or crutches? (If yes, check affected area in the box below)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Head	<input type="checkbox"/> Neck	<input type="checkbox"/> Shoulder
<input type="checkbox"/> Hand/Fingers	<input type="checkbox"/> Chest	<input type="checkbox"/> Upper Back
<input type="checkbox"/> Knee	<input type="checkbox"/> Calf/Shin	<input type="checkbox"/> Ankle
<input type="checkbox"/> Upper Arm	<input type="checkbox"/> Elbow	<input type="checkbox"/> Forearm
<input type="checkbox"/> Lower Back	<input type="checkbox"/> Hip	<input type="checkbox"/> Thigh
<input type="checkbox"/> Foot/Toes		



	Y	N
12) Have you ever had a stress fracture?	<input type="checkbox"/>	<input type="checkbox"/>
13) Have you ever been told that you have, or have you had an X-ray for atlantoaxial (neck) instability?	<input type="checkbox"/>	<input type="checkbox"/>
14) Do you regularly use a brace or assistive device?	<input type="checkbox"/>	<input type="checkbox"/>
15) Has a doctor told you that you have asthma or allergies?	<input type="checkbox"/>	<input type="checkbox"/>
16) Do you cough, wheeze or have difficulty breathing during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
17) Is there anyone in your family who has asthma?	<input type="checkbox"/>	<input type="checkbox"/>
18) Have you ever used an inhaler or taken asthma medication?	<input type="checkbox"/>	<input type="checkbox"/>
19) Were you born without, are you missing, or do you have a nonfunctioning kidney, eye, testicle or any other organ?	<input type="checkbox"/>	<input type="checkbox"/>
20) Have you had infectious mononucleosis (mono) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>
21) Do you have any rashes, pressure sores or other skin problems?	<input type="checkbox"/>	<input type="checkbox"/>
22) Have you had a herpes skin infection?	<input type="checkbox"/>	<input type="checkbox"/>
23) Have you ever had an injury to your face, head, skull or brain (including a concussion, confusion, memory loss or headache from a hit to your head, having your "bell rung" or getting "dinged")?	<input type="checkbox"/>	<input type="checkbox"/>
24) Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>
26) Have you ever had numbness, tingling or weakness in your arms or legs after being hit, falling, stingers or burners?	<input type="checkbox"/>	<input type="checkbox"/>
27) While exercising in the heat, do you have severe muscle cramps or become ill?	<input type="checkbox"/>	<input type="checkbox"/>
28) Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	<input type="checkbox"/>	<input type="checkbox"/>
29) Have you ever been tested for sickle cell trait?	<input type="checkbox"/>	<input type="checkbox"/>
30) Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
31) Do you wear glasses or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
32) Do you wear protective eyewear, such as goggles or a face shield?	<input type="checkbox"/>	<input type="checkbox"/>
33) Are you happy with your weight?	<input type="checkbox"/>	<input type="checkbox"/>
34) Are you trying to gain or lose weight?	<input type="checkbox"/>	<input type="checkbox"/>
35) Has anyone recommended you change your weight or eating habits?	<input type="checkbox"/>	<input type="checkbox"/>
36) Do you limit or carefully control what you eat?	<input type="checkbox"/>	<input type="checkbox"/>
37) Do you have any concerns that you would like to discuss with a doctor?	<input type="checkbox"/>	<input type="checkbox"/>

Females Only

	Y	N
38) Have you ever had a menstrual period?	<input type="checkbox"/>	<input type="checkbox"/>
39) How old were you when you had your first menstrual period?	_____	
40) How many periods have you had in the last year?	_____	

Explain "Yes" Answers Here



2018-19 ANNUAL PREPARTICIPATION PHYSICAL EXAMINATION

The physician should fill out this form with assistance from the parent or guardian.)

Student Name: _____

Date of Birth: _____

Patient History Questions: Please Tell Me About Your Child...

	Y	N
1) Has your child fainted or passed out DURING or AFTER exercise, emotion or startle?	<input type="checkbox"/>	<input type="checkbox"/>
2) Has your child ever had extreme shortness of breath during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
3) Has your child had extreme fatigue associated with exercise (different from other children)?	<input type="checkbox"/>	<input type="checkbox"/>
4) Has your child ever had discomfort, pain or pressure in his/her chest during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
5) Has a doctor ever ordered a test for your child's heart?	<input type="checkbox"/>	<input type="checkbox"/>
6) Has your child ever been diagnosed with an unexplained seizure disorder?	<input type="checkbox"/>	<input type="checkbox"/>
7) Has your child ever been diagnosed with exercise-induced asthma not well controlled with medication?	<input type="checkbox"/>	<input type="checkbox"/>

Family History Questions: Please Tell Me About Any Of The Following In Your Family...

	Y	N			
8) Are there any family members who had sudden/unexpected/unexplained death before age 50? (including SIDS, car accidents, drowning or near drowning)	<input type="checkbox"/>	<input type="checkbox"/>			
9) Are there any family members who died suddenly of "heart problems" before age 50?	<input type="checkbox"/>	<input type="checkbox"/>			
10) Are there any family members who have unexplained fainting or seizures?	<input type="checkbox"/>	<input type="checkbox"/>			
11) Are there any relatives with certain conditions, such as:	<input type="checkbox"/>	<input type="checkbox"/>			
Enlarged Heart	<input type="checkbox"/>	<input type="checkbox"/>	Catecholaminergic Polymorphic Ventricular Tachycardia (CPVT)	<input type="checkbox"/>	<input type="checkbox"/>
Hypertrophic Cardiomyopathy (HCM)	<input type="checkbox"/>	<input type="checkbox"/>	Arrhythmogenic Right Ventricular Cardiomyopathy (ARVC)	<input type="checkbox"/>	<input type="checkbox"/>
Dilated Cardiomyopathy (DCM)	<input type="checkbox"/>	<input type="checkbox"/>	Marfan Syndrome (Aortic Rupture)	<input type="checkbox"/>	<input type="checkbox"/>
Heart Rhythm Problems	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack, Age 50 or Younger	<input type="checkbox"/>	<input type="checkbox"/>
Long QT Syndrome (LQTS)	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker or Implanted Defibrillator	<input type="checkbox"/>	<input type="checkbox"/>
Short QT Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	Deaf at Birth	<input type="checkbox"/>	<input type="checkbox"/>
Brugada Syndrome	<input type="checkbox"/>	<input type="checkbox"/>			

Explain "Yes" Answers Here

I hereby state that, to the best of my knowledge, my answers to all of the above questions are complete and correct. Furthermore, I acknowledge and understand that my eligibility may be revoked if I have not given truthful and accurate information in response to the above questions.

Signature of Athlete _____

Signature of Parent/Guardian _____

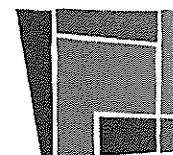
Date _____

Signature of MD/DO/ND/NMD/NP/PA-C/CCSP _____

Date _____

GUIDE TO ARIZONA IMMUNIZATIONS REQUIRED FOR ENTRY

Child Care or Preschool (birth – 5 years)



ADHS

Requirements by age at entry and on a continuing review status. Vaccines must follow minimum intervals and ages to be valid. A 4-day grace period applies in most situations.

Vaccine	2 Months	4 Months	6 Months	12 Months	15 Months	18+ Months
Hepatitis B (Hep B or HBV)	Hep B 1* (see pg. 2)	Hep B 2	Hep B 3 (received at 24 weeks of age or older and by 12 mos of age)		Documented 3 or 4 doses Note: If Hep B #3 was given before 24 weeks of age, a 4 th dose is needed.	
Diphtheria, Tetanus, and Pertussis	DTaP 1	DTaP 2	DTaP 3	---	DTaP 4	Documented 4 doses
<i>Haemophilus influenzae</i> type b (Hib)	Hib 1	Hib 2	Hib 3** (see pg.2)	---	Hib 4** (see pg. 2)	Documented 3-4 doses
Poliomyelitis (Polio) (IPV or OPV)	Polio 1	Polio 2	---	Polio 3	Documented 3 doses	
Measles, Mumps and Rubella (MMR)	---	---	---	MMR 1	Documented 1 dose Note: MMR and Varicella must be given on the same day or at least 28 days apart	
Varicella (chickenpox) (VAR)	---	---	---	VAR 1	Documented 1 dose Note: MMR and Varicella must be given on the same day or at least 28 days apart	
Hepatitis A (Maricopa County only)	---	---	---	Hep A 1***		Hep A 2 (due 6 months after dose 1)
Summary of vaccines required for 15 months to Pre-kindergarten	<p>All of these doses are required at 15 months of age and older: 3 Hep B, 4 DTaP, 3 Polio, 1 MMR, 1 Varicella, and 3-4 Hib or 1 Hib dose given at/after 15 months.</p> <p>***2 doses of Hepatitis A are required for children 1-5 years old in Maricopa County only, but are recommended in all other counties.</p>					

Please see reverse for additional information and exceptions and conditions to the rules.

Arizona Immunization Program Office • 150 North 18th Avenue, Suite 120
 Phoenix, AZ 85007 • (602) 364-3630

GUIDE TO ARIZONA IMMUNIZATIONS REQUIRED FOR ENTRY

Child Care or Preschool

The laws and rules governing child care and preschool immunization requirements are Arizona Revised Statutes §15-884; and Arizona Administrative Code, R9-5-305 & R9-6-701–708. Please review the child care requirements in Table 7.1 and “catch-up” schedule in Table 7.2, located in R9-6-701-708.

Students must have proof of all required immunizations in order to attend child care or preschool. Parental recall or verbal history of any disease is not accepted; therefore these students must submit an ADHS medical exemption form. **Specifically with varicella (chickenpox), measles, or rubella disease a medical exemption with attached laboratory evidence of immunity is required.**

A child who is missing vaccines required for his age can start child care but must get a dose of each vaccine due within 15 days of enrollment and bring a copy of the immunization record completed by the clinic to the child care facility. **After 15 days, the child may not attend child care without documentation that the child has received the required vaccinations.**

Arizona law allows child care immunization exemptions for medical reasons, lab evidence of immunity, and religious beliefs. For further information and guidance please review the Arizona Immunization Handbook for Schools and Child Care Programs along with Frequently Asked Questions.

Additional Information on vaccine requirements:

- **Hep B:** *Hep B dose #1 is required for babies 0-2 months attending child care. Minimum intervals for valid doses are as follows: The 2nd dose is due at least 4 weeks after the 1st dose; the 3rd dose is due at least 8 weeks after the 2nd dose and at least 16 weeks after the 1st dose. The final dose of hepatitis B vaccine (HBV) must be at or after 24 weeks of age. If Hep B 3rd dose was given before 24 weeks of age, a 4th dose is needed.
- **DTaP:** The 2nd dose is due 4 weeks after the 1st dose; the 3rd dose is due 4 weeks after the 2nd dose; the 4th dose is due 6 months after the 3rd dose.
- **Hib:** If child is 7-14 months of age, doses are given 2 months apart. If child is at least 15 months old and less than 5 years, a single dose is needed to catch up. A Hib dose at/after 12 months is required for all children under 5 years.
**If Pedvax Hib is used for the first two doses, only 3 total doses are needed and the 3rd dose of Hib is not due until 12-15 months of age.
- **Poliomyelitis (Polio):** The 2nd dose is due 4 weeks after the 1st dose; the 3rd dose is due 4 weeks after the 2nd dose. If the child is 4+ years of age, the 3rd Polio may qualify as the child's final dose, but must have a 6 month interval between the last two Polio doses.

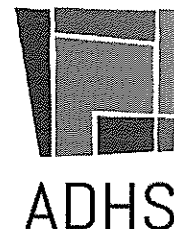
The U.S. currently does not give anything other than IPV (inactivated polio vaccine) whereas some foreign countries still give the OPV (oral polio vaccine). OPV given prior to April 1, 2016 will be presumed to be trivalent and therefore acceptable, regardless of country of administration. Any OPV doses administered after April 1, 2016 are presumed to be bivalent and therefore unacceptable.

- **Hep A: Required for Maricopa County only; Recommended for all other counties.** Children 1 through 5 years of age are required to obtain dose #1 within 15 days of enrollment in child care, preschool or Head Start. Dose #2 is due 6 months after dose #1.



Arizona Immunization Program Office • 150 North 18th Avenue, Suite 120
Phoenix, AZ 85007 • (602) 364-3630

GUIDE TO ARIZONA IMMUNIZATIONS REQUIRED FOR SCHOOL ENTRY GRADES K-12



Immunization requirements by age and grade for school attendance. Vaccines must follow minimum intervals and ages to be valid. A 4-day grace period applies in most situations.

Vaccine	4-6 Years Old Kindergarten or 1 st grade	7-10 Years Old	11 Years and Older
Hepatitis B (Hep B or HBV)	3 doses 3 doses acceptable if dose #3 was received at or after 24 weeks of age; otherwise 4 doses are required with the final dose at or after 24 weeks of age.		
Poliomyelitis/ Polio (IPV or OPV)	4 doses 3 doses acceptable if dose #3 was received on or after 4 years of age. Students who received 3 or 4 doses (with 4 weeks minimum intervals between doses) PRIOR to August 7, 2009 have met the requirement. The final dose of polio administered ON or AFTER August 7, 2009 must be given at a minimum of 4 years of age AND a minimum interval of 6 months following the previous dose. Polio is not required for students who are 18 years of age or older.		
Measles, Mumps and Rubella (MMR or MMR-V)	2 doses Minimum recommended age for dose #1 is 12 months. A 3 rd dose will be required if dose #1 was given more than 4 days before 1 st birthday. MMR and Varicella must be given on the same day or at least 28 days apart		
Varicella (chickenpox) (VAR or MMR-V)	1 dose Minimum recommended age for dose #1 is 12 months. 2 doses are required if the 1 st dose was given at 13 years of age or older. MMR and Varicella must be given on the same day or at least 28 days apart		
Diphtheria, Tetanus, and Pertussis	5 doses of DTaP, DTP or DT 4 doses acceptable if last dose was given on or after 4 years of age. A 6th dose is required if 5 doses have been given before 4 years of age.	4 doses of DTaP, DTP, DT, Tdap or Td 3 doses acceptable if first dose was given on or after 1 st birthday. Tdap given at ages 7-10 will meet the 11-year-old+ Tdap requirement.	1 dose of Tdap is required Students must have a minimum of 3 doses of tetanus/diphtheria vaccine which may include 1 Tdap. If Tdap has not been previously given, 1 dose of Tdap is required when at least 5 years has passed since the last dose of tetanus-containing vaccine.
Quadrivalent Meningococcal (MenACWY or MCV4)	1 dose of quadrivalent meningococcal ACWY is required. A dose administered at 10 years of age will meet the requirement.		

Please see reverse for additional information and exceptions and conditions to the rules.

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GUIDE TO IMMUNIZATIONS REQUIRED FOR ARIZONA SCHOOL ENTRY

GRADES K-12

The laws and rules governing school immunization requirements are Arizona Revised Statutes §15-871-874; and Arizona Administrative Code, R9-6-701-708. Please review the school requirements in Table 7.1 and "catch-up" schedule in Table 7.2, located in R9-6-701-708.

Students must have proof of all required immunizations in order to attend school. Parental recall or verbal history of any disease is not accepted; therefore these students must submit an ADHS medical exemption form. **Specifically with varicella (chickenpox), measles, or rubella disease a medical exemption with attached laboratory evidence of immunity is required.** Arizona law allows K-12 immunization exemptions for medical reasons, lab evidence of immunity, and personal beliefs.

Homeless students and children in foster care are allowed a 5-day grace period to submit proof of immunization records (assuming that all other students have their immunization records submitted prior to attendance at school).

For further information and guidance please review the [Arizona Immunization Handbook for Schools and Child Care Programs](#) along with [Frequently Asked Questions](#).

Quick-Look Vaccine Exceptions and Conditions

- **Hepatitis B** – A child has received the required number of doses of hepatitis B virus (HBV) vaccine to qualify for Arizona school and child care/preschool attendance if **all** of the following apply:
 - ✓ There are at least 4 weeks between the 1st and 2nd dose of HBV vaccine;
 - ✓ There are at least 8 weeks between the 2nd and final dose of HBV vaccine;
 - ✓ There are at least 16 weeks (4 months) between the 1st and final dose of HBV vaccine;
 - ✓ **AND** the child received the final dose of HBV vaccine when they were at least 24 weeks of age.
- **Hepatitis B for students aged 11-15 years** – 2 doses meet the requirement if adult hepatitis B vaccine (Recombivax) was received. Dosage (10mcg/1.0mL) and type of vaccine must be clearly documented. If Recombivax was not the vaccine used, a 3-dose series is required.
- **Meningococcal Vaccine** – Only quadrivalent meningococcal ACWY vaccine doses will be accepted. The only quadrivalent meningococcal vaccines given currently in the U.S. are Menactra and Menveo. The Meningococcal Polysaccharide vaccine (Menomune) was a quadrivalent vaccine so is acceptable; however, production of this vaccine was discontinued in February 2017. Students who received this polysaccharide vaccine are considered acceptable for school requirements. No monovalent or bivalent meningococcal vaccinations will be accepted (MenA, MenB, MenC, or MenC/Y).
- **Poliomyelitis (Polio)** – The U.S. currently does not give anything other than IPV (inactivated polio vaccine) whereas some foreign countries still give the OPV (oral polio vaccine). OPV given prior to April 1, 2016 will be presumed to be trivalent and therefore acceptable, regardless of country of administration. Any OPV doses administered after April 1, 2016 are presumed to be bivalent and therefore unacceptable.
- **Td Booster** – A Td booster is required 10 years after the last dose of a tetanus-containing vaccine if student is still enrolled in school.





ARIZONA SCHOOL IMMUNIZATION RECORD

For use in grades K-12



This form is to be completed by school staff from immunization records provided by parent or guardian and supplemented by information from ASIS. See reverse side for instructions.

I. IDENTIFICATION INFORMATION

Child's Name		Nombre De Niño		Birth Date		Fecha De Nacimiento										
Entry Grade (Circle)		Grado (Marque Con Circulo)		Sex		Sexo										
K	1	2	3	4	5	6	7	8	9	10	11	12	Male	Niño	Female	Mujer

II. IMMUNIZATIONS		1st	2nd	3rd	4th	5th	6th	F/U Date
		MO/DA/YR	MO/DA/YR	MO/DA/YR	MO/DA/YR	MO/DA/YR	MO/DA/YR	MO/DA/YR
(DTP/DTP) Diphtheria, Tetanus & Pertussis								
Difteria, Tetano y Tos Ferina								
(Td) Tetanus & Diphtheria								
Tetano y Difteria								
(Tdap) Tetanus, Diphtheria, acellular Pertussis								
Tetano, Difteria y Tos Ferina								
(IPV/OPV) Polio Vaccine								
Vacuna Antipoliomielitica								
(MMR) Measles, Mumps & Rubella								
Sarampión, y Paperas, y Rubéola								
(Hep B) Hepatitis B								
La Vacuna Hepatitis B								
Varicella (Chickenpox)								
Varicela								
Check box if pupil attended childcare/school in AZ with parental recall of chicken pox before 9/1/11								
Meningococcal								
Meningococcos								
(Hep A) Hepatitis A								
La Vacuna Hepatitis A								
HPV (Human Papilloma Virus)								
Virus Papilloma Humano								
(Flu) Haemophilus Influenzae b								
Required for Pre-K program, children age 2 months to age 5 years.								
Influenzae Haemophilus tipo B								
Influenza (Flu) Vaccine								
Other								
TB Skin Test: (optional)								
List most recent test								
Prueba de tuberculosis del piel: (opcional)								
Liste la mas reciente prueba								

REQUIRED FOR SCHOOL

This record is part of the mandatory permanent pupil records as defined in Arizona Revised Statute 15-874 and shall transfer with that record. State and local health departments shall have access to this record.

FOR SCHOOL USE ONLY:

School Name	Nombre de Escuela
Contact Person	Persona de Contacto
Phone Number	Número de Teléfono
Initial Enrollment Date in an Arizona School/Preschool	

III. Documentation Presented:

<input type="checkbox"/> Arizona Lifetime Record	
<input type="checkbox"/> Foreign country (name)	
<input type="checkbox"/> Out-of-State record (name)	
<input type="checkbox"/> ASIS	
<input type="checkbox"/> Provider Record	
<input type="checkbox"/> Other	

IV. Status of Requirements

A. <input type="checkbox"/> Currently up-to-date, more doses are due later.	
B. <input type="checkbox"/> Needs follow-up (see follow-up column).	
C. <input type="checkbox"/> No immunization record provided.	

(reason)

D. <input type="checkbox"/> Medical Exemption—Permanent	
Date	/ /
E. <input type="checkbox"/> Laboratory evidence of immunity attached:	
F. <input type="checkbox"/> Medical Exemption—Temporary until	
Date	/ /
G. <input type="checkbox"/> Personal Beliefs	
Date	/ /

I certify that I reviewed this student's immunization record and it has been transcribed accurately.

Date	/ /
Admitting Official	

Comment Section:

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INSTRUCTIONS FOR COMPLETION OF THE ARIZONA SCHOOL IMMUNIZATION RECORD (ASIR 109R)

(To be completed by school personnel)

I. IDENTIFICATION INFORMATION:

Complete the information section with the name, birth date, grade at entrance and sex of pupil.

II. IMMUNIZATION:

Fill in date (month/day/year) of each immunization the student has received from the record(s) presented by the parent or guardian. School staff may use information from the ASIIS program to supplement immunization data. A copy of the original/official immunization record(s) provided by the parent/guardian at time of enrollment (and any updates thereafter) should be attached to the ASIR and kept in the student's health file.

Parental recall of immunizations is not acceptable. The full date of month/day/year is required for MMR, and for all vaccine doses administered on or after 01/01/2003.

III. DOCUMENTATION PRESENTED:

Mark box(es) to indicate the type of immunization record(s) used to transcribe information onto ASIR 109R.

IV. STATUS OF REQUIREMENTS Check the correct box(s):

- A. Determine if the immunizations are complete by reviewing the school immunization requirements posted at <http://azdhs.gov/phs/immunization/school-childcare/requirements.htm>.
- B. If the pupil has not met all requirements, and needs additional doses according to Arizona School Immunization requirements, add date when the next vaccination dose is due in the F/U Column.
- C. If no immunization records are presented for the pupil, please check box C and write in the reason, i.e., homeless, group home, transfer student, or other reason.
- D. If the pupil is to be exempted for medical reasons, a Medical Exemption Form must be signed by a physician or nurse practitioner and the parent or guardian and attached to ASIR 109R. If the medical exemption is permanent, the requirement for the immunization is met.
- E. If the pupil has met the immunity requirement with laboratory evidence, the Medical Exemption Form must be completed and attached to the ASIR 109R, along with the laboratory evidence of immunity, which must be disease specified.
- F. If the medical exemption is temporary, check box F and the date the exemption will no longer be valid. Once the length of time for the exemption has ended, the child must receive the necessary immunization(s) or be subject to exclusion from school.
- G. If the pupil is to be exempt for reasons of personal belief, the parent or guardian must sign a Personal Beliefs Exemption Form indicating they received the information about immunizations provided by ADHS and have been informed of the risks of not vaccinating their child.

V. SCHOOL STAFF

Fill in date and your signature as the school representative who reviewed the immunization record. (Admitting official may be the school nurse, health office personnel, or office staff member)

U.S. Vaccines: Table 1

(For Combination Vaccines, See Table 2)

Vaccine	Trade Name	Abbreviation	Manufacturer	Type / Route	Approved	Comments
Adenovirus	Adenovirus Type 4 & Type 7		Barr Labs Inc.	Live Viral / Oral (tablets)	2011	Approved for military populations 17 through 50 years.
Anthrax	BioThrax®	AVA	Emergent BioSolutions	Inactivated Bacterial / IM	1970	Age range 18 through 65 years
Cholera	Vaxchora®		PaxVax	Live Bacterial / Oral	2016	Age range 18 through 64 years.
DTaP	Daptacel®	DTaP	sanofi	Inactivated Toxoids and Bacterial / IM	2002	Age range 6 weeks through 6 years.
	Infanrix®	DTaP	GlaxoSmithKline	Inactivated Toxoids and Bacterial / IM	1997	Age range 6 weeks through 6 years.
DT	Generic	DT	sanofi	Inactivated Bacterial Toxoids / IM	1978	Age range 6 months through 6 years.
<i>Haemophilus influenzae</i> type b (Hib)	ActHIB®	Hib (PRP-T)	sanofi	Inactivated Bacterial / IM	1993	3-dose primary series
	Hiberix®	Hib (PRP-T)	GlaxoSmithKline	Inactivated Bacterial / IM	2009	3-dose primary series
	PedvaxHIB®	Hib (PRP-OMP)	Merck	Inactivated Bacterial / IM	1989	2-dose primary series
Hepatitis A	Havrix®	HepA	GlaxoSmithKline	Inactivated Viral / IM	1995	Pediatric & adult formulations. Minimum age = 1 year
	Vaqta®	HepA	Merck	Inactivated Viral / IM	1996	Pediatric & adult formulations. Minimum age = 1 year
Hepatitis B	Engerix-B®	HepB	GlaxoSmithKline	Recombinant Viral / IM	1989	Pediatric & adult formulations. Minimum age = birth
	Recombivax HB®	HepB	Merck	Recombinant Viral / IM	1986	Pediatric & adult formulations. Minimum age = birth
	Hepelisav-B®	HepB	Dynavax Technologies	Recombinant Viral / IM	2017	Adjuvanted Minimum age = 18 years
Herpes Zoster (Shingles)	Zostavax®	ZVL	Merck	Live Attenuated Viral / SC	2006	One dose; Minimum age = 50 years. (ACIP recommends ≥60 years.)
	Shingrix®	RZV	GlaxoSmithKline	Recombinant Viral / IM	2017	Two doses; Minimum age = 50 years.
Human Papillomavirus (HPV)	Gardasil® 9	9vHPV	Merck	Inactivated Viral / IM	2014	Approved for males and females 9 through 26 years.

Vaccine	Trade Name	Abbreviation	Manufacturer	Type / Route	Approved	Comments
Influenza	Afluria®	IIV3 IIV4	Seqirus	Inactivated Viral / IM	2007 2016	Minimum age = 5 years
	Fluad®	IIV3	Seqirus	Inactivated Viral / IM	2015	Adjuvanted Minimum age = 65 years
	Fluarix®	IIV4	GlaxoSmithKline	Inactivated Viral / IM	2012	Minimum age = 6 months
	Flublok®	RIV3 RIV4	sanofi	Recombinant Viral / IM	2013	Egg Free Minimum age = 18 years
	Flucelvax®	ccIIV4	Seqirus	Cell-culture Viral / IM	2016	Minimum age = 4 years
	FluLaval®	IIV4	GlaxoSmithKline	Inactivated Viral / IM	2013	Minimum age = 6 months
	FluMist®	LAIV4	Medimmune	Live Attenuated Viral / Intranasal (spray)	2003	Age range 2 through 49 years
	Fluvirin®	IIV3	Seqirus	Inactivated Viral / IM	1988	Minimum age = 4 years
	Fluzone®	IIV3 IIV4	sanofi	Inactivated Viral / IM	1980 2013	Minimum age = 6 months
	Fluzone® High-Dose	IIV3	sanofi	Inactivated Viral / IM	2009	Minimum age = 65 years
Japanese encephalitis	Fluzone® Intradermal	IIV4	sanofi	Inactivated Viral / Intradermal	2011	Age range 18 through 64 years
	Ixiaro®	JE	Valneva	Inactivated Viral / IM	2009	Minimum age = 2 months
Measles, Mumps, Rubella	M-M-R® II	MMR	Merck	Live Attenuated Viral / SC	1978 (First MMR – 1971)	Minimum age = 12 months
Meningococcal	Menactra®	MCV4 MenACWY	sanofi	Inactivated Bacterial / IM	2005	Age range 9 months through 55 years
	Menveo®	MCV4 MenACWY	GlaxoSmithKline	Inactivated Bacterial / IM	2010	Age range 2 months through 55 years
	Trumenba®	MenB	Pfizer	Recombinant Bacterial / IM	2014	Age range 10 through 25 years
	Bexsero®	MenB	GlaxoSmithKline	Recombinant Bacterial / IM	2015	Age range 10 through 25 years

Vaccine	Trade Name	Abbreviation	Manufacturer	Type / Route	Approved	Comments
Pneumococcal	Pneumovax® 23	PPSV23	Merck	Inactivated Bacterial / SC or IM	1983	Minimum age = 2 years
	Prevnar 13®	PCV13	Pfizer	Inactivated Bacterial / IM	2010 (PCV7 – 2000)	Minimum age = 6 weeks
Polio	Ipol®	IPV	sanofi	Inactivated Viral / SC or IM	1990 (IPV-1955)	Minimum age = 6 weeks
Rabies	Inovax® Rabies		sanofi	Inactivated Viral / IM	1980	All ages
	RabAvert®		GlaxoSmithKline	Inactivated Viral / IM	1997	All ages
Rotavirus	RotaTeq®	RV5	Merck	Live Viral / Oral (liquid)	2006	3-dose series 1 st dose 6 through 14 weeks 3 rd dose max age 8 months 0 days
	Rotarix®	RV1	GlaxoSmithKline	Live Viral / Oral (liquid)	2008	2-dose series 1 st dose 6 through 14 weeks 2 nd dose max age 8 months 0 days
Tetanus, (reduced) Diphtheria	Tenivac®	Td	sanofi	Inactivated Bacterial Toxoids / IM	2003	Minimum age = 7 years
	(Generic)	Td	Massachusetts Biological Labs	Inactivated Bacterial Toxoids / IM	1967	Minimum age = 7 years
Tetanus, (reduced) Diphtheria, (reduced) Pertussis	Boostrix®	Tdap	GlaxoSmithKline	Inactivated Bacterial / IM	2005	Minimum age = 10 years
	Adacel®	Tdap	sanofi	Inactivated Bacterial / IM	2005	Age range 10 through 64 years
Typhoid	Typhim Vi®		sanofi	Inactivated Bacterial / IM	1994	Minimum age = 2 years
	Vivotif®		PaxVax	Live Attenuated Bacterial / Oral (4 capsules)	1989	Minimum age = 6 years
Varicella	Varivax®	VAR	Merck	Live Attenuated Viral / SC	1995	Minimum age = 12 months
Vaccinia (Smallpox)	ACAM2000®		sanofi	Live Attenuated Viral / Percutaneous	2007	All ages
Yellow Fever	YF-Vax®	YF	sanofi	Live Attenuated Viral / SC	1978	Minimum age = 9 months

U.S. Vaccines: Table 2

(Combination Vaccines)

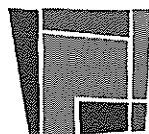
Vaccine	Trade Name	Abbreviation	Manufacturer	Type / Route	Approved	Comments
DTaP, Polio	Kinrix®	DTaP-IPV	GlaxoSmithKline	Inactivated Bacterial & Viral / IM	2008	Approved for 5 th (DTaP) and 4 th (IPV) booster at 4-6 years
	Quadrace TM	DTaP-IPV	sanofi	Inactivated Bacterial & Viral / IM	2015	Approved for 5 th (DTaP) and 4 th (IPV) booster at 4-6 years
DTaP, hepatitis B, Polio	Pediarix®	DTaP-HepB-IPV	GlaxoSmithKline	Inactivated Bacterial & Viral / IM	2002	Age range 6 weeks through 6 years
DTaP, Polio, <i>Haemophilus influenzae</i> type b	Pentacel®	DTaP-IPV/Hib	sanofi	Inactivated Bacterial & Viral / IM	2008	Age range 6 weeks through 4 years
Hepatitis A, Hepatitis B	Twinrix®	HepA-HepB	GlaxoSmithKline	Inactivated/Recombinant Viral / IM	2001	Pediatric HepA + Adult HepB Minimum age = 18 years
Measles, Mumps, Rubella, Varicella	ProQuad®	MMRV	Merck	Live Attenuated Viral / SC	2005	Age range 1 through 12 years

Abbreviations

The abbreviations on this table (Column 3) were standardized jointly by staff of the Centers for Disease Control and Prevention, ACIP Work Groups, the editor of the *Morbidity and Mortality Weekly Report (MMWR)*, the editor of *Epidemiology and Prevention of Vaccine-Preventable Diseases* (the *Pink Book*), ACIP members, and liaison organizations to the ACIP.

These abbreviations are intended to provide a uniform approach to vaccine references used in ACIP Recommendations and Policy Notes published in the *MMWR*, the *Pink Book*, and the American Academy of Pediatrics *Red Book*, and in the U.S. immunization schedules for children, adolescents, and adults.

In descriptions of combination vaccines, dash (–) indicates: products in which the active components are supplied in their final (combined) form by the manufacturer; slash (/) indicates: products in which active components must be mixed by the user.



ARIZONA DEPARTMENT OF HEALTH SERVICES

Personal Beliefs Exemption Form

Kindergarten – 12th Grade Only

Arizona Department of Health Services (ADHS) strongly supports immunization as one of the easiest and most effective tools in preventing diseases that can cause serious illness and even death. ADHS also respects the rights of parents to decide whether or not to vaccinate their child.

By state law, (A.R.S. §15-873) a child will not be allowed to attend school until either proof of immunization or a completed exemption form is submitted to the school. The information below is provided to ensure that parents are informed about the risks of not vaccinating.

Place an "X" in the box to the left of the disease(s) listed to exempt your child from the vaccine. Initial and date the box on the right.

<input type="checkbox"/>	Diphtheria (DTaP, Tdap, Td): I have been informed that by not receiving this vaccine, my child may be at increased risk of developing diphtheria if exposed to this disease. Serious symptoms and effects of this disease include: heart failure, paralysis (can't move parts of the body), breathing problems, coma, and death.	Initials _____ Date _____
<input type="checkbox"/>	Tetanus (DTaP, Tdap, Td): I have been informed that by not receiving this vaccine, my child may be at increased risk of developing tetanus if exposed to this disease. Serious symptoms and effects of this disease include: "locking" of the jaw, difficulty in swallowing and breathing, seizures (jerking and staring), painful tightening of muscles in the head and neck, and death.	Initials _____ Date _____
<input type="checkbox"/>	Pertussis (Whooping Cough) (DTaP, Tdap): I have been informed that by not receiving this vaccine, my child may be at increased risk of developing pertussis (whooping cough) if exposed to this disease. Serious symptoms and effects of this disease include: severe coughing fits that can cause vomiting and exhaustion, pneumonia, seizures (jerking and staring), brain damage, and death.	Initials _____ Date _____
<input type="checkbox"/>	Polio (IPV): I have been informed that by not receiving this vaccine, my child may be at increased risk of developing polio if exposed to this disease. Serious symptoms and effects of this disease include: paralysis (can't move parts of the body), meningitis (infection of the brain and spinal cord covering), permanent disability, and death.	Initials _____ Date _____
<input type="checkbox"/>	Measles, Mumps, Rubella (MMR): I have been informed that by not receiving this vaccine, my child may be at increased risk of developing measles, mumps, and/or rubella if exposed to these diseases. Serious symptoms and effects of measles include: pneumonia, seizures (jerking and staring), brain damage, and death. Serious symptoms and effects of mumps include: meningitis (infection of the brain and spinal cord covering), painful swelling of the testicles or ovaries, sterility, deafness, and death. Serious symptoms and effects of rubella include: rash, arthritis, and muscle or joint pain. If a woman gets rubella while she is pregnant, she could have a miscarriage or her baby could be born with serious birth defects such as deafness, heart problems, and brain damage.	Initials _____ Date _____
<input type="checkbox"/>	Hepatitis B: I have been informed that by not receiving this vaccine, my child may be at increased risk of developing hepatitis B if exposed to this disease. Serious symptoms and effects of this disease include: jaundice (yellow skin or eyes), life-long liver problems, such as scarring and liver cancer, and death.	Initials _____ Date _____
<input type="checkbox"/>	Varicella (Chickenpox): I have been informed that by not receiving this vaccine, my child may be at increased risk of developing varicella (chickenpox) if exposed to this disease. Serious symptoms and effects of this disease include: severe skin infections, pneumonia, brain damage, and death.	Initials _____ Date _____
<input type="checkbox"/>	Meningococcal: I have been informed that by not receiving this vaccine, my child may be at increased risk of developing meningococcal disease. Serious symptoms and effects of this disease include: brain damage, sepsis (systemic infection) permanent scarring or loss of limbs, and death.	Initials _____ Date _____

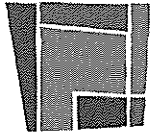
Due to my personal beliefs, I request an exemption for my child from the required vaccine doses selected above. I am aware that if I change my mind in the future, I can rescind this exemption and obtain immunizations for my child.

Initials _____

- I am aware that additional information about vaccine preventable diseases, vaccines and reduced or no cost vaccination services are available from my local county health department and Arizona Department of Health Services (www.azdhs.gov/phs/immunization/).
- I am aware that in the event the state or county health department declares an outbreak of a vaccine-preventable disease for which I cannot provide proof of immunity for my child, he or she may not be allowed to attend school until the risk period ends, which may be 3 weeks or longer.

Child's Name _____ Date of Birth (month/day/year) _____

Parent/Guardian Signature _____ Date (month/day/year) _____



Medical Exemption Form

Arizona law requires that schools, preschools and child care facilities retain this form in order for a child to be exempted from immunization requirements for medical reasons.

This is the official ADHS-provided format used by licensed physicians and registered nurse practitioners to document that 1) due to the child's health or medical condition, the child may be adversely affected on a temporary or permanent basis by one or more of the required vaccine doses; 2) a child has laboratory evidence of immunity to one or more specific vaccine-preventable diseases and lab results are attached (**required** for measles, rubella, and varicella); or 3) the child has a documented medical history of disease OR laboratory evidence of immunity for diseases other than measles, rubella, and varicella.

Child's Name _____ Date of Birth _____

To be completed by a licensed physician or registered nurse practitioner to exempt a child from school or child care immunization requirements.

Printed Name of Physician or Nurse _____

Signature of Physician or Nurse _____ Date _____

Please list each vaccine included in the exemption and the reason for the exemption:

Please indicate whether this is a **permanent** exemption ☐ or a **temporary** exemption ☐

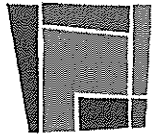
If the exemption is **temporary**, please list the date the exemption ends _____

Parent/Guardian Section:

1. I am aware that in the event the state or county health department declares an outbreak of a vaccine-preventable disease for which I cannot provide proof of immunity for my child, he or she may not be allowed to attend child care and/or school until the risk period ends, which may be 3 weeks or longer.
2. I am aware that additional information about vaccine preventable diseases, vaccines, and reduced or no cost vaccination services is available from my local county health department and Arizona Department of Health Services. (www.azdhs.gov/phs/immun/).

Parent/Guardian Signature _____ Date _____

Arizona Revised Statutes 15-873, <http://www.azleg.gov/ArizonaRevisedStatutes.asp?Title=15>, and Arizona Administrative Code, R9-5-305, http://apps.azsos.gov/public_services/Title_09/9-05.pdf, and R9-6-706, http://apps.azsos.gov/public_services/Title_09/9-06.pdf describe the requirements for medical exemptions in childcare and school settings.



Religious Beliefs Exemption Form

For Child Care, Preschool and Head Start Programs

Arizona Department of Health Services (ADHS) strongly supports immunization as one of the easiest and most effective tools in preventing diseases that can cause serious illness and even death. ADHS also respects the rights of parents who are raising their child in a religion whose teachings are in opposition to immunization to make the decision not to vaccinate their child.

Place an "X" in the box to the left of the disease(s) listed to exempt your child from the vaccine. Initial and date the box on the right.

<input type="checkbox"/>	Diphtheria (DTaP, Tdap, Td): I have been informed that by not receiving this vaccine, my child may be at increased risk of developing diphtheria if exposed to this disease. Serious symptoms and effects of this disease include: heart failure, paralysis (can't move parts of the body), breathing problems, coma, and death.	Initials _____ Date _____
<input type="checkbox"/>	Tetanus (DTaP, Tdap, Td): I have been informed that by not receiving this vaccine, my child may be at increased risk of developing tetanus if exposed to this disease. Serious symptoms and effects of this disease include: "locking" of the jaw, difficulty in swallowing and breathing, seizures (jerking and staring), painful tightening of muscles in the head and neck, and death.	Initials _____ Date _____
<input type="checkbox"/>	Pertussis (Whooping Cough) (DTaP, Tdap): I have been informed that by not receiving this vaccine, my child may be at increased risk of developing pertussis (whooping cough) if exposed to this disease. Serious symptoms and effects of this disease include: severe coughing fits that can cause vomiting and exhaustion, pneumonia, seizures (jerking and staring), brain damage, and death.	Initials _____ Date _____
<input type="checkbox"/>	Polio: I have been informed that by not receiving this vaccine, my child may be at increased risk of developing polio if exposed to this disease. Serious symptoms and effects of this disease include: paralysis (can't move parts of the body), meningitis (infection of the brain and spinal cord covering), permanent disability, and death.	Initials _____ Date _____
<input type="checkbox"/>	Measles, Mumps, Rubella (MMR): I have been informed that by not receiving this vaccine, my child may be at increased risk of developing measles, mumps, and/or rubella if exposed to these diseases. Serious symptoms and effects of measles include: pneumonia, seizures (jerking and staring), brain damage, and death. Serious symptoms and effects of mumps include: meningitis (infection of the brain and spinal cord covering), painful swelling of the testicles or ovaries, sterility, deafness, and death. Serious symptoms and effects of rubella include: rash, arthritis, and muscle or joint pain. If a woman gets rubella while she is pregnant, she could have a miscarriage or her baby could be born with serious birth defects such as deafness, heart problems, and brain damage.	Initials _____ Date _____
<input type="checkbox"/>	Haemophilus Influenza type b (Hib): I have been informed that by not receiving this vaccine, my child may be at increased risk of developing Hib if exposed to this disease. Serious symptoms and effects of this disease include: meningitis (infection of the brain and spinal cord covering), pneumonia, severe swelling in the throat that makes it hard to breathe, infections of the blood, joints, bones, and covering of the heart, and death.	Initials _____ Date _____
<input type="checkbox"/>	Hepatitis B: I have been informed that by not receiving this vaccine, my child may be at increased risk of developing hepatitis B if exposed to this disease. Serious symptoms and effects of this disease include: jaundice (yellow skin or eyes), life-long liver problems, such as scarring and liver cancer, and death.	Initials _____ Date _____
<input type="checkbox"/>	Hepatitis A: I have been informed that by not receiving this vaccine, my child may be at increased risk of developing hepatitis A if exposed to this disease. Serious symptoms and effects of this disease include: jaundice (yellow skin or eyes), "flu-like" illness, hospitalization, and death.	Initials _____ Date _____
<input type="checkbox"/>	Varicella (Chickenpox): I have been informed that by not receiving this vaccine, my child may be at increased risk of developing varicella (chickenpox) if exposed to this disease. Serious symptoms and effects of this disease include: severe skin infections, pneumonia, brain damage, and death.	Initials _____ Date _____

Due to my religious beliefs, I request an exemption for my child from the required vaccine doses selected above. I am aware that if I change my mind in the future, I can rescind this exemption and obtain immunizations for my child.

Initials _____

- I am aware that additional information about vaccine preventable diseases, vaccines and reduced or no cost vaccination services is available from my local county health department and Arizona Department of Health Services (www.azdhs.gov/phs/immun/).
- I am aware that in the event the state or county health department declares an outbreak of a vaccine-preventable disease for which I cannot provide proof of immunity for my child, he or she may not be allowed to attend child care until the risk period ends, which may be 3 weeks or longer.

Child's Name _____ Date of Birth (month/day/year) _____

Parent/Guardian Signature _____ Date (month/day/year) _____



Immunization Screening and Referral Form for Child Care and Preschool

Our records show that your child has not received all immunizations required for child care/preschool attendance by Arizona State Law (Arizona Administrative Code R9-5-305). The immunization doses due now are circled or highlighted.

Student Name: _____

Date of Birth: _____

School/Facility Name: _____

Date of Notice: _____

Contact Person at School/Facility: _____ Phone Number : _____

In accordance with Arizona State Law, students in school or child care must have proof of all required immunizations in order to attend. Lack of proper documentation may result in your child being excluded from school or child care until such documentation is provided to your school health office. Your child's immunization record with the below missing immunization(s) must be submitted:

By this Date: _____ (15 days from notification date)

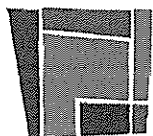
1. If your child has already received the necessary immunization(s), bring his or her immunization record to the school or child care facility. The record must show the child's name, date of birth, the date that all doses were received, and the name of the physician or health agency who administered the vaccine.
2. If your child has not received the necessary immunizations, take your child's immunization record and this form to your physician, local health department, or other vaccine provider to get required immunization(s) and/or records. Then bring this form and the updated record back to the school or child care facility.

School/Child Care Staff: Please Circle or Highlight the Missing Required Dose(s) for the Corresponding Required Vaccine(s).

Required Vaccine	Dose Missing			
DTaP/DTP/DT (Diphtheria, Tetanus, Pertussis)	1	2	3	4
Hib (haemophilus influenza type b)	1	2	3	4 ^x
IPV (Polio)	1	2	3	
MMR (Measles, Mumps, Rubella)	1			
Hepatitis B	1	2	3	4 ^x
Varicella (Chickenpox)	1			
Hepatitis A *	1	2		
CDC Recommended Vaccine**	Dose Missing			
Hepatitis A*	1	2		
Rotavirus	1	2	3	
Seasonal Influenza (Flu)	1			
Pneumococcal (PCV13)	1	2	3	4

- * Hepatitis A vaccination is only a **requirement** for child care entry in Maricopa county, however, it is a **recommended** vaccine for children in ALL counties, for children 12 months and older.
- ** CDC: Center for Disease Control and Prevention → through the Advisory Committee on Immunization Practices (ACIP) recommends routine vaccinations to prevent vaccine-preventable diseases. While most vaccinations are required by the State of Arizona for school/child care entry, there are other **recommended immunizations** your child may need.
- * Exceptions exist for these particular doses- see the Arizona child care and preschool immunizations requirements for details and guidance:
<https://www.azdhs.gov/documents/preparedness/epidemiology-disease-control/immunization/school-childcare/immunizations-preschool.pdf>

Immunization Screening and Referral Form for Kindergarten-12th Grade



ADHS

Our records show that your child has not received all immunizations required for school attendance by Arizona State Law (Arizona Revised Statutes §15-872). The immunization doses required now are circled or highlighted.



Student Name: _____

Date of Birth: _____

School Name: _____

Date of Notice: _____

Contact Person at School: _____

Phone Number: _____

In accordance with Arizona State Law, students must have proof of all required immunizations in order to attend school. Lack of proper documentation may result in your child being excluded from school until such documentation is provided to your school health office. Your child's immunization record with the below missing immunization(s) must be submitted:

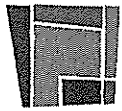
By this Date: _____

1. If your child has already received the necessary immunization(s), bring his or her immunization record to the school. The record must show the child's name, date of birth, the date that all doses were received, and the name of the physician or health agency who administered the vaccine.
2. If your child has not received the necessary immunizations, **take your child's immunization record and this form to your physician, local health department, or other vaccine provider to get required immunization(s) and/or records. Then bring this form and the updated record back to school.**

School Staff: Please Circle or Highlight the Missing Required Dose(s) for the Corresponding Required Vaccine(s).

School Required Vaccine	Dose Missing					
DTaP/DTP/DT (Diphtheria, Tetanus, Pertussis)	1	2	3	4	5 [*]	6 [*]
Td (Tetanus, Diphtheria)	1	2	3 [*]	4 [*]		
Tdap (Tetanus, Diphtheria, Pertussis)	1					
IPV (Polio)	1	2	3	4 [*]		
MMR (Measles, Mumps, Rubella)	1	2	3 [*]			
Hepatitis B	1	2	3	4 [*]		
Varicella (Chickenpox)	1	2 [*]				
Meningococcal (MCV4/quadrivalent)	1	2 [*]				
CDC Recommended Vaccine**	Dose Missing					
Hepatitis A	1	2				
HPV (Human Papillomavirus)	1	2	3			
Seasonal Influenza (Flu)	1					

- * Indicates that a second dose is highly **recommended by the CDC** but not required for school attendance.
- ** CDC: Center for Disease Control and Prevention → through the Advisory Committee on Immunization Practices (ACIP) recommends routine vaccinations to prevent vaccine-preventable diseases. While most vaccinations are required by the State of Arizona for school entry, there are other **recommended immunizations** your child may need.
- * Exceptions exist for these particular doses- see the Arizona school immunizations requirements for details and guidance: <https://www.azdhs.gov/documents/preparedness/cpid/cpid-mitology-disease-control/immunization/school-childcare/school-immunization-requirements.pdf>



DIRECTIONS: Please complete and submit this form to ASIISHelpDesk@azdhs.gov

Organization Name: _____

Physical Address: _____

City: _____ State: _____ Zip: _____ County: _____

Phone #: (____) _____ FAX #: (____) _____

Organization Main Contact: _____

E-mail address: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____ County: _____

Please report all facility information on page 2.

Type of Organization:
(Select only one)

- ☐ Family or General Practice
- ☐ Pediatrics Practice
- ☐ Family Health Center
- ☐ School-Based Clinic or Family Resource and Wellness Center
- ☐ Indian Health Service Unit (IHS/Tribal Health Center)
- ☐ County Health Department
- ☐ Private Hospital
- ☐ Public Hospital
- ☐ Community Health Center (FQHC)
- ☐ Rural Health Center (RHC)
- ☐ Other (please specify) _____

Please contact ASIISHelpDesk@azdhs.gov if you have any questions.

Facility #1

Name: _____
Physical Address: _____
City: _____ State: _____ Zip: _____ County _____
Phone #: (____) _____ FAX #: (____) _____
Facility Contact: _____
E-mail address: _____
Mailing Address: _____
City: _____ State: _____ Zip: _____ County _____

Facility #2

Name: _____
Physical Address: _____
City: _____ State: _____ Zip: _____ County _____
Phone #: (____) _____ FAX #: (____) _____
Facility Contact: _____
E-mail address: _____
Mailing Address: _____
City: _____ State: _____ Zip: _____ County _____

Facility #3

Name: _____
Physical Address: _____
City: _____ State: _____ Zip: _____ County _____
Phone #: (____) _____ FAX #: (____) _____
Facility Contact: _____
E-mail address: _____
Mailing Address: _____
City: _____ State: _____ Zip: _____ County _____

Facility #4

Name: _____
Physical Address: _____
City: _____ State: _____ Zip: _____ County _____
Phone #: (____) _____ FAX #: (____) _____
Facility Contact: _____
E-mail address: _____
Mailing Address: _____
City: _____ State: _____ Zip: _____ County _____

Arizona State Immunization Information System (ASIIS) User Information

Organization Name: _____

Facility Name: _____

The following methods will be used to report immunization information to the ASIIS Registry:

- ☐ Web Application (Direct access to the registry via the Internet)
☐ Electronic Medical Record (EMR) via HL7 v2.5.1

Name of PMS/EMR: _____ Name of Vendor: _____

Please list the full name, email and select a user privilege for each staff members who will use the web application.

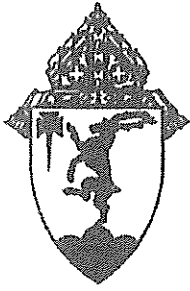
- View Privilege means you can only look at the patient record and immunization record.
- Edit Privilege means you can view, add and make changes to patient and immunization record.

Name	Email Address	Privilege
		<input type="radio"/> View <input type="radio"/> Edit
		<input type="radio"/> View <input type="radio"/> Edit
		<input type="radio"/> View <input type="radio"/> Edit
		<input type="radio"/> View <input type="radio"/> Edit
		<input type="radio"/> View <input type="radio"/> Edit
		<input type="radio"/> View <input type="radio"/> Edit
		<input type="radio"/> View <input type="radio"/> Edit
		<input type="radio"/> View <input type="radio"/> Edit

All Users shall electronically accept the terms of the Pledge to Protect Confidential Information on their first login.

Please contact ASIISHelpDesk@azdhs.gov if you have any questions.

ASIIS is a computer based immunization registry and tracking system implemented by the Arizona Department of Health Services and its partners. It is intended to aid health care professionals and other users who have a need to check a client's immunization status according to A.R.S § 36-135, R9-6-707, and R9-6-708. Through ASIIS, providers can place orders for publicly funded vaccines to provide to children eligible to receive VFC vaccines. Client-specific information and vaccine ordering privileges are only available to authorized users and the Arizona Department of Health Services. The Users enters into this agreement with the Arizona Department of Health Services and agree to adhere to all requirements that are listed in the Pledge to Protect Confidential Information.



DIOCESE OF TUCSON CATHOLIC SCHOOLS

STAFF DOCUMENTATION OF IMMUNITY TO MEASLES, MUMPS, AND RUBELLA

NAME: _____ **DOB:** _____
(Print) Last First M.I.

SCHOOL: _____

PLEASE COMPLETE APPROPRIATE INFORMATION. Written documentation must confirm the vaccines and serologic tests. Attach documentation to this form and file in personnel file. See reverse side for further explanation.

____ **VACCINATION:**

MEASLES: ____/____/____ **MUMPS:** ____/____/____ **RUBELLA:** ____/____/____
(Date) (Date) (Date)

Or

MMR: #1 ____/____/____ #2 ____/____/____
(Date) (Date)

Or

____ **LABORATORY/SEROLOGY TEST (BLOOD TITER):**

MEASLES: Lab test date with written physician or lab confirmation ____/____/____.

MUMPS: Lab test date with written physician or lab confirmation ____/____/____.

RUBELLA: Lab test date with written physician or lab confirmation ____/____/____.

Information verified by: _____ Date _____

COMPLETE IF APPROPRIATE:

____ My physical condition is such that the required immunization would seriously endanger my health. I understand I will be unable to work during a declared outbreak.

____ My religion/personal belief is opposed to such immunizations. I understand I will be unable to work during a declared outbreak.

Signature _____ Date _____

STAFF DOCUMENTATION OF MEASLES, MUMPS, AND RUBELLA

Faculty and Staff of all schools in the Diocese of Tucson shall show proof of immunity to Measles, Mumps, and Rubella.

Employees in child care centers, schools, universities, hospitals, and other public and private medical care facilities are considered high risk and must have proof of immunity to Measles, Mumps, and Rubella in order to remain at work during a declared outbreak.

Persons can be considered immune to Measles, Mumps, and Rubella if they:

- Have valid documentation of adequate vaccination. Documentation must be kept in the employee's personnel file.

Or,

- Have physician or local/state health officer-signed documentation of serologic evidence of immunity (i.e., positive blood titer) to Measles, Mumps, and Rubella. Documentation must be kept in the employee's personnel file.

MMR VACCINE IS THE VACCINE OF CHOICE FOR ANY REQUIRED DOSES.

State guidelines vary--Arizona recommends two doses for school personnel and requires two doses for medical personnel. Written verification from a physician or an immunization record must confirm the immunizations. The first MMR must have been given on or after the first birthday.

An employee who seeks an exemption for health, religious, or personal reasons will likely be excluded from work during an outbreak of any of these diseases--see following explanation:

IMPORTANT: During a declared outbreak of Measles, Mumps, or Rubella, the County Health Department and/or Arizona Department of Health Services will, in accordance with its rules and regulations, determine the conditions of work exclusion for non/under-immunized individuals, including the specific length of time. Exclusions may be very long, e.g., if Mumps is confirmed, exclusion from work may be for 26 days after the onset of the last case. One case of Rubella and/or Measles is considered to be an "outbreak."

**COUNTY HEALTH DEPARTMENTS
WITHIN THE DIOCESE OF TUCSON**

COCHISE COUNTY HEALTH DEPARTMENT

1415 Melody Lane, Bldg. A
Bisbee, AZ 85603
Phone: (520) 432-9400

GILA COUNTY HEALTH DEPARTMENT

5515 South Apache Ave. Suite 100
Globe, AZ 85501
Phone: (928) 402-8811

GRAHAM COUNTY HEALTH DEPARTMENT

826 W. Main Street
Safford AZ 85546
Phone: (928) 428-1962

GREENLEE COUNTY HEALTH DEPARTMENT

253 Fifth St
P.O. Box 936
Clifton, AZ 85533
Phone: (928) 865-2601

LA PAZ COUNTY HEALTH DEPARTMENT

1112 Joshua Ave, Suite #206
Parker, AZ 85344
Phone: (928) 669-1100

PIMA COUNTY HEALTH DEPARTMENT

3950 S. Country Club Road Ste. 100
Tucson, AZ 85714
Phone: (520) 724-7770

PINAL COUNTY HEALTH DEPARTMENT

P.O. Box 2945
971 N. Jason Lopez Circle, Building D
Florence, AZ 85132
Phone: (866) 960-0633

SANTA CRUZ COUNTY HEALTH DEPARTMENT

2150 N. Congress Drive
Nogales, AZ 85621
Phone: (520) 375-7800

YUMA COUNTY HEALTH DEPARTMENT

2200 W. 28th Street
Yuma, AZ 85364
Phone: (928) 317-4550

DIOCESE OF TUCSON SCHOOL HEALTH GUIDELINES

HEALTH SCREENING GRID

The following grid shows the screening assessments mandated (**M**) or recommended (**R**) for Diocese of Tucson schools. The hearing screening schedule is the minimum required by the State of Arizona.

Grade \ Test	Pre-K	K	1	2	3	4	5	6	7	8
Height/Weight/BMI		R	R	R	R	R	R	R	R	R
Far Vision ¹		R	R	R	R	R	R	R		
Strabismus	R	R	R	R	R					
Color Vision ²			R							
Hearing ³	M	M	M	M				M		
Scoliosis ⁴							R	R	R	R
Blood Pressure								R		R

Grade	9	10	11	12
Height/Weight/BM	R	R	R	R
Far Vision ¹	R			
Hearing ³	M			
Scoliosis ⁴	R			
Blood Pressure ⁵				R

¹ In addition to the grades indicated, students who are new to the school and have no record of a test the previous year; who are receiving special education assistance; or who have been referred by a teacher or parent should be tested.

² Test is done on new students in grades 2 - 8 if there is no documentation of previous testing.

³ In addition to the grades indicated, the following students should be tested:

- A student in grade 3, 4, or 5, unless there is documentation of screening in or after grade 2;
- A student in grade 7 or 8, unless there is documentation of screening in or after grade 6;
- A student in grade 10, 11, or 12, unless there is documentation of screening in or after grade 9;
- A student receiving special education;
- A student who failed a second hearing screening in the prior school year; and
- A student who is referred by self, parent, or any school faculty or staff.

Students with documented hearing loss or hearing devices do not need to be screened.

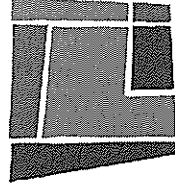
⁴ This test requires parental permission.

⁵ Assessment recommended in grade 9, 10, or 11 if there is no record of previous testing.

Hearing Screening Program Report

School year: 2017-2018

This form is to be used only to be a guide as to the hearing screening information needed to be submitted online. <http://www.azdhs.gov/prevention/womens-childrens-health/qchcn/index.php#hearing-screening>



ARIZONA DEPARTMENT
OF HEALTH SERVICES

DO NOT MAIL THIS FORM TO THE ARIZONA DEPARTMENT OF HEALTH SERVICES

I. School Information

School's Complete Name:		County Type District School (CTDS)- 9 DIGITS -----	
(if applicable, no spaces and no dashes):			
Type of School:	<input type="checkbox"/> Public <input type="checkbox"/> Private <input type="checkbox"/> Charter <input type="checkbox"/> Preschool <input type="checkbox"/> Kindergarten	Other (Please specify) _____	
District Name/Charter Holder Name:		School's Phone Number:	
School's (not district) Address:		City:	
Zip Code:		Fax Number:	

II. Screening Process Information

Did your school conducted a second hearing screening within 30-45 days on those students who required a second screening?				Yes	No	
Start and End Date of School Year: (mm/dd/yyyy to mm/dd/yyyy)						
Initial Screening Date (the first date you begin to screen students: (mm/dd/yyyy)						
Screenings performed by (select all that apply) <input type="checkbox"/> Screener(s) <input type="checkbox"/> Volunteer(s) <input type="checkbox"/> Audiologist (Please include name and license number) _____						
Screeners: (Names)	(Screen 1)	(Screen 2)	(Screen 3)	(Screen 4)	(Screen 5)	(Screen 6)
	(Screen 7)	(Screen 8)	(Screen 9)	(Screen 10)	(Screen 11)	(Screen 12)
*Hearing screener(s)' certificates must be valid at time of screening and must reflect training on equipment used.						
Does your school have an audiologist?		<input type="checkbox"/> No	<input type="checkbox"/> Yes, (Audiologist—please include name and license number) _____			
Does your school have a licensed school nurse?		<input type="checkbox"/> No	Dedicated (only works at your school). Please include the name _____		Shared (school nursed is shared throughout the district). Please include the name _____	

III. Reporter Information

Report Completed by: (Name)								
Report Completed by: (Title)	<input type="checkbox"/> Administrative Assistant	<input type="checkbox"/> Audiologist	<input type="checkbox"/> Director	<input type="checkbox"/> Health Aide	<input type="checkbox"/> Hearing Screener	<input type="checkbox"/> Nurse Assistant	<input type="checkbox"/> School's Nurse	<input type="checkbox"/> Other (Please specify) _____
Report completed by: (email address)								
Report completed by: (date) (mm/dd/yyyy)								

IV. Equipment Information

Used ADHS Equipment:		<input type="checkbox"/> Yes (Only ADHS)	<input type="checkbox"/> No (Used own equipment)	<input type="checkbox"/> Both (ADHS and own equipment)
Equipment Calibration Date(s) : (Only if used own equipment) (mm/dd/yyyy)				
Type of equipment used (only fill out the information that is applicable for your school)	<input type="checkbox"/> Audiometer	<input type="checkbox"/> Tympanometer	<input type="checkbox"/> OAE	<input type="checkbox"/> Other (Please specify) _____

V. Hearing Information by Grade (only fill out the information that is applicable for your school)

	Preschool	Kdg	First	Second	Third	Fourth	Fifth	Sixth	Seventh	Eight	Ninth	Tenth	Eleventh	Twelfth	Special Ed. (not to be included in other grades)
1. Number of students enrolled at initial screening.															
2. Number of students that parents opted out of screening.															
3. Number of students with a written diagnosis or evaluation from an audiologist stating that the student is deaf or hard of hearing.															
4. Number of students with a hearing aid, assistive listening device, or a cochlear implant.															
5. Number of students not screened.															
6. Number of students screened this year.															
7. Number of students that did not pass first screening.															
8. Number of students that received second screening.															
9. Number of students that did not pass second screening.															
10. Number of students referred for further evaluation.															
11. Number of students evaluated by medical provider.															
12. Number of students evaluated by school audiologist.															
13. Number of students evaluated by audiologist (other than the school's).															
14. Number of students identified deaf or hard of hearing this year.															
15. Comments (provide any comments regarding student screenings by grade).															

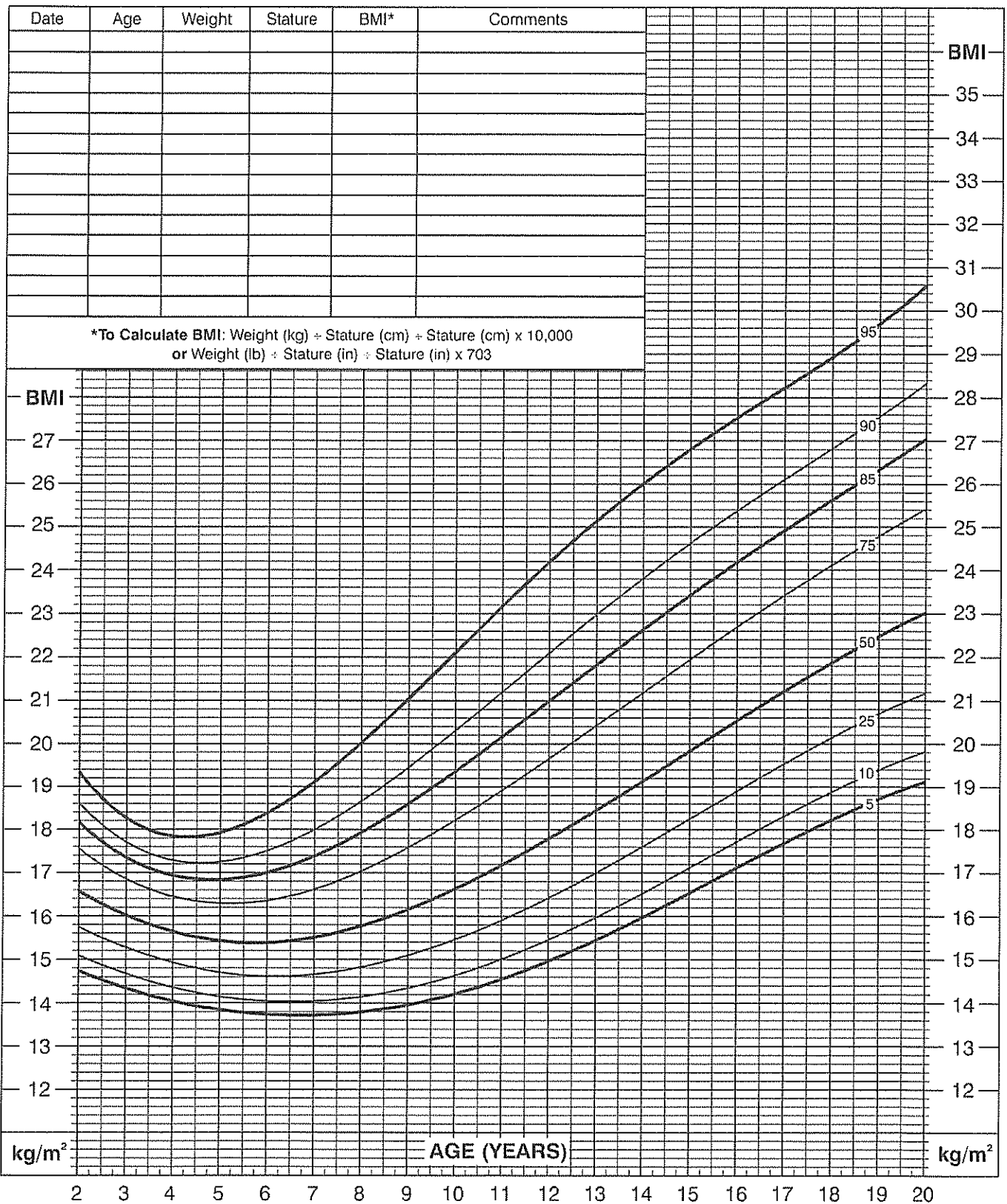
VI. Additional Questions Regarding Student's Health Indicators

1. Cumulative number of students enrolled in your school on the last day of the school year.	
2. Number of dedicated Licensed Registered Nurses in your school.	
3. Number of shared Licensed Registered Nurses in your school.	
4. Number of students with an Asthma diagnosis.	
5. Number of students with Diabetes diagnosis.	
6. Number of students with life threatening allergy (anaphylactic reaction).	
7. What electronic system does your school use to collect/capture the hearing screening data? Ex. Synergy, CHIP, etc.	

2 to 20 years: Boys
Body mass index-for-age percentiles

NAME _____

RECORD # _____



Published May 30, 2000 (modified 10/16/00).

SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000).
<http://www.cdc.gov/growthcharts>

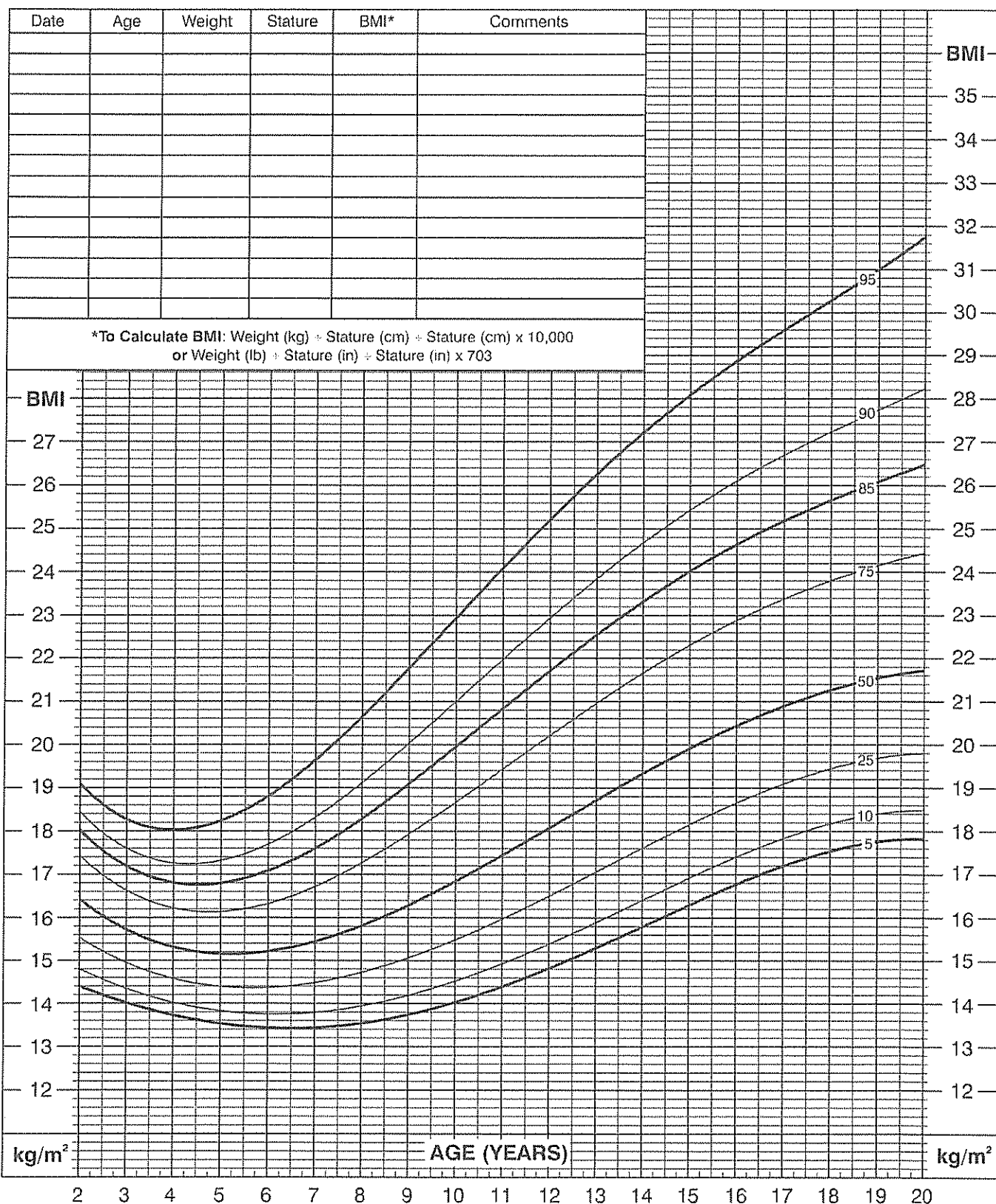


SAFER • HEALTHIER • PEOPLE

2 to 20 years: Girls
Body mass index-for-age percentiles

NAME _____

RECORD # _____



Blood Pressure Referral Levels for Boys by Age and Height Percentile

Age (Year) ↓	BP Percentile ↓	Systolic BP (mmHg)							Diastolic BP (mmHg)						
		← Percentile of Height →							← Percentile of Height →						
		-----							-----						
		5th	10th	25th	50th	75th	90th	95th	5th	10th	25th	50th	75th	90th	95th
5	95th	108	109	110	112	114	115	116	69	70	71	72	73	74	74
	99th	115	116	118	120	121	123	123	77	78	79	80	81	81	82
6	95th	109	110	112	114	115	117	117	72	72	73	74	75	76	76
	99th	116	117	119	121	123	124	125	80	80	81	82	83	84	84
7	95th	110	111	113	115	117	118	119	74	74	75	76	77	78	78
	99th	117	118	120	122	124	125	126	82	82	83	84	85	86	86
8	95th	111	112	114	116	118	119	120	75	76	77	78	79	79	80
	99th	119	120	122	123	125	127	127	83	84	85	86	87	87	88
9	95th	113	114	116	118	119	121	121	76	77	78	79	80	81	81
	99th	120	121	123	125	127	128	129	84	85	86	87	88	88	89
10	95th	115	116	117	119	121	122	123	77	78	79	80	81	81	82
	99th	122	123	125	127	128	130	130	85	86	86	88	88	89	90
11	95th	117	118	119	121	123	124	125	78	78	79	80	81	82	82
	99th	124	125	127	129	130	132	132	86	86	87	88	89	90	90
12	95th	119	120	122	123	125	127	127	78	79	80	81	82	82	83
	99th	126	127	129	131	133	134	135	86	87	88	89	90	90	91
13	95th	121	122	124	126	128	129	130	79	79	80	81	82	83	83
	99th	128	130	131	133	135	136	137	87	87	88	89	90	91	91
14	95th	124	125	127	128	130	132	132	80	80	81	82	83	84	84
	99th	131	132	134	136	138	139	140	87	88	89	90	91	92	92
15	95th	126	127	129	131	133	134	135	81	81	82	83	84	85	85
	99th	134	135	136	138	140	142	142	88	89	90	91	92	93	93
16	95th	129	130	132	134	135	137	137	82	83	83	84	85	86	87
	99th	136	137	139	141	143	144	145	90	90	91	92	93	94	94
17	95th	131	132	134	136	138	139	140	84	85	86	87	87	88	89
	99th	139	140	141	143	145	146	147	92	93	93	94	95	96	97

From: *Update on the 1987 Task Force Report on High Blood Pressure in Children and Adolescents: A Working Group Report from the National High Blood Pressure Education Program--October, 1995*

Blood Pressure Referral Levels for Girls by Age and Height Percentile

Age (Year) ↓	BP Percentile ↓	Systolic BP (mmHg)							Diastolic BP (mmHg)						
		← Percentile of Height →							← Percentile of Height →						
		5th	10th	25th	50th	75th	90th	95th	5th	10th	25th	50th	75th	90th	95th
		5th	10th	25th	50th	75th	90th	95th	5th	10th	25th	50th	75th	90th	95th
5	95th	107	107	108	110	111	112	113	70	71	71	72	73	73	74
	99th	114	114	116	117	118	120	120	78	78	79	79	80	81	81
6	95th	108	109	110	111	113	114	115	72	72	73	74	74	75	76
	99th	115	116	117	119	120	121	122	80	80	80	81	82	83	83
7	95th	110	111	112	113	115	116	116	73	74	74	75	76	76	77
	99th	117	118	119	120	122	123	124	81	81	82	82	83	84	84
8	95th	112	112	114	115	116	118	118	75	75	75	76	77	78	78
	99th	119	120	121	122	123	125	125	82	82	83	83	84	85	86
9	95th	114	114	115	117	118	118	120	76	76	76	77	78	79	79
	99th	121	121	123	124	125	127	127	83	83	84	84	85	86	89
10	95th	116	116	117	119	120	121	122	77	77	77	78	79	80	80
	99th	123	123	125	126	127	129	129	84	84	85	86	86	87	88
11	95th	118	118	119	121	122	123	124	78	78	78	79	80	81	81
	99th	125	125	126	128	129	130	131	85	85	86	87	87	88	89
12	95th	119	120	121	123	124	125	126	79	79	79	80	81	82	82
	99th	127	127	128	130	131	132	133	86	86	87	88	88	89	90
13	95th	121	122	123	124	126	127	128	80	80	80	81	82	83	83
	99th	128	129	130	132	133	134	135	87	87	88	89	89	90	91
14	95th	123	123	125	126	127	128	129	81	81	81	82	83	84	84
	99th	130	131	132	133	135	136	136	88	88	89	90	90	91	92
15	95th	124	125	126	127	129	130	131	82	82	82	83	84	85	85
	99th	131	132	133	134	136	137	138	89	89	90	91	91	92	93
16	95th	125	126	127	128	130	131	132	82	82	83	84	85	85	86
	99th	132	133	134	135	137	138	139	90	90	90	91	92	93	93
17	95th	125	126	127	129	130	131	132	82	83	84	84	85	85	86
	99th	133	133	134	136	137	138	139	90	90	91	91	92	93	93

From: *Update on the 1987 Task Force Report on High Blood Pressure in Children and Adolescents: A Working Group Report from the National High Blood Pressure Education Program--October, 1995*

SCOLIOSIS SCREENING

Dear Parents,

We will be performing Scoliosis exams for students in grades 5 - 8 on _____ as part of the annual school health screening days. We require parental permission to conduct this exam.

Scoliosis is a lateral S-shaped curvature of the spine which often becomes noticeable between 9 and 13 years of age. *If your child participates in sports--requiring an annual physical exam--the Scoliosis screening should have been done by your doctor* and it would not be necessary for us to do the exam again. Each child with parental permission is examined privately by a medical professional (RN, MD, DO, NP, PA, or LPT). The examination is very short and simple, consisting mainly of observing the students' backs in a few specific postures, without shirts on. Girls can wear a sports bra or swimsuit top for their exam. If any significant abnormalities are observed, a letter will be sent home to you advising a further examination by your doctor.

If you would like to have your son or daughter examined, please complete the form on the back and return to the school nurse as soon as possible. Please return *one form for each child to be examined (grades 5-8 only)*.

Sincerely,

**SIGNED PERMISSION FROM A PARENT MUST BE OBTAINED BEFORE THE
EXAMINATION.**

I would like my son/daughter examined for scoliosis:

Name of Child _____ Grade _____ Teacher _____

Parent's Signature _____ Date _____

SPINAL SCREENING FORM

Student Name _____ DOB _____ Gender (M / F)

School _____ Grade/Teacher _____

Date Screened _____ Examiner _____

RN () PT () PA () MD () Other () _____

Date(s) Re-screened _____ Re-screen Examiner _____ RN or MD

Check if Child Shows Any of the Following:

Screen

Rescreening
1-2 wks 6 mnths



I. Student Standing, Facing Examiner

1. Posture-Head and neck not centered.
2. Uneven shoulders.
3. Uneven hips, accentuated waist crease on one side.
4. Unequal arm-body space.
5. Unequal arm length--one arm shorter than other.

1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____



II. Forward Bend, Facing Examiner

6. Unequal rib and/or lumbar prominence on one side.

6. _____	_____	_____
----------	-------	-------



III. Student Standing, Back to Examiner

7. Uneven shoulder.
8. Uneven scapula.
9. Uneven hip, accentuated waist crease on one side.
10. Unequal arm-body space.
11. Visible lateral curvature of spine.

7. _____	_____	_____
8. _____	_____	_____
9. _____	_____	_____
10. _____	_____	_____
11. _____	_____	_____



IV. Forward Bend, Back to Examiner

12. Unequal rib and/or lumbar prominence on one side.

12. _____	_____	_____
-----------	-------	-------



V. Student Standing, Side to Examiner

13. Accentuated round back (Kyphosis).
14. Accentuated swayback (Lordosis).

13. _____	_____	_____
14. _____	_____	_____



VI. Forward Bend, Side to Examiner

15. Exaggeration of smooth arch of thoracic spine.

15. _____	_____	_____
-----------	-------	-------

Re-Screening (not for round back deformity)

Measurement of hump - **Thoracic** _____ inch or _____ degrees* **Lumbar** _____ inch or _____ degrees*

Student Referred - No _____ Yes _____ Date Referral Letter Sent: _____

Diagnosis Previously Known - Currently Under Treatment - Yes _____ No _____

* Determined by using a Scoliometer.

(SCHOOL LOGO)

HEARING CONSERVATION PROGRAM REFERRAL

Parents/Guardian: Please give this report form to your health care provider when your child is examined.

School _____ Date _____

Name _____ Gr. _____ DOB _____

Parent/Guardian _____

Address _____

School hearing screening and follow-up re-screening with pure tone audiometry indicated that this student needs further evaluation. This screening is NOT conclusive; therefore, it is recommended that this child be seen by a health care provider for a complete hearing evaluation.

FOLLOW-UP HEARING EVALUATION

Results of the evaluation: _____

Hearing status: _____

Physician's findings and recommendations: _____

Will this student be returning to you for further care? _____ Date of return: _____

Physician's Name (Printed)

Physician's Signature

Date

Return to: Name _____ Title _____

Address: _____

(SCHOOL LOGO)

SCHOOL VISION SCREENING REFERRAL

Parents/Guardian: Please give this report form to the doctor when your child is examined.

School _____ Date _____

Name _____ Gr. _____ DOB _____

Parent/Guardian _____

Address _____

School vision screening with follow-up re-screening indicated that this student needs further evaluation. This screening is NOT conclusive, therefore it is recommended that this child be seen by a health care provider for a complete eye examination.

FOLLOW-UP VISION EXAMINATION

Diagnosis: _____

When should glasses be worn? _____

Examiner's findings and recommendations: _____

When should this student be reexamined? _____

Examiner's Name (Printed) and Title

Examiner's Signature

Date

Return to: Name _____ Title _____

Address: _____

RESULTS OF HEIGHT/WEIGHT/BODY MASS INDEX (BMI) SCREENING

School _____

Date _____

Dear Parent/Guardian,

Your child, _____, was measured for height and weight during a recent health screening. Body Mass Index (BMI) was calculated based on height and weight. BMI is a simple method of screening for weight categories that may lead to health problems.

Your child's results were:

Height _____ Weight _____ BMI _____ BMI-for-age percentile _____

Doctors and nurses use guidelines to identify underweight, normal weight, at-risk-of-overweight, and overweight in children. These guidelines are based on the BMI-for-age percentiles as follows:

Underweight	BMI less than 5 %ile
Within normal range	BMI 5 %ile to 85 %ile
At risk of overweight	BMI 85 %ile to 94 %ile
Overweight	BMI 95 %ile or greater

BMI is not a final measure of underweight or overweight. Things like amount of daily activity or history of illnesses in a family can influence height and weight in children and adolescents. Increased muscle from sports or physical activities can also increase BMI.

Your child's results are outside the normal range by BMI result. I encourage you to share these results with your child's healthcare provider. S/he is the best person to say whether your child's measurements are within a healthy range. S/he may recommend changes in eating, physical activity, or other areas.

Please call me if you have any questions or concerns about the results of this BMI measurement.

Sincerely,

BLOOD PRESSURE SCREENING REFERRAL FORM

Dear Parent/Guardian:

Blood Pressure screening is one of the preventive health services provided by the School Health Program. Your child was recently screened as part of our annual school health screening week.

It is recommended that a student be referred to his/her health care provider for further examination with the blood pressure is elevated at three different times. Your child had the following readings:

<u>Date of Screening</u>	<u>Blood Pressure Reading</u>	<u>Arm Used</u>
1. _____	_____	Rt. _____ Lt. _____
2. _____	_____	Rt. _____ Lt. _____
3. _____	_____	Rt. _____ Lt. _____

Based on the above blood pressure readings, I would suggest that your health care provider examine your child. Please have him/her complete the form below and return to the school nurse/health coordinator as soon as possible.

School Nurse: _____ School: _____

Address: _____ Phone: _____

Physician's Report of Blood Pressure Examination

Student's Name: _____

Examination Findings:

Recommendation and/or treatment (include blood pressure monitoring/frequency at school):

Physician's Printed Name: _____ Phone: _____

Signature: _____ Date: _____

Please return this form to your child's school nurse/health office staff member.

Spinal Screening Referral

Date: _____

Dear Parent,

During the recent spinal screening held at our school, your child showed signs of spinal variations. Physician follow-up is needed to determine if your child has a spinal problem.

Will you please take this report with you when you take your child to your family physician, pediatrician, or orthopedic physician for follow-up examination and evaluation.

Following the examination please sign the Release of Information consent below and return this form with completed Physician's Report to your child's school. If you need further information or have questions, please call me.

Child's Name _____ DOB _____ Grade/Room _____
Nurse _____ Telephone # _____

SCREENING REPORT

- | | |
|--|---|
| 1. _____ Uneven shoulders | 2. _____ Unequal arm-body space |
| 3. _____ Uneven hips, accentuated waist crease on one side | 4. _____ Unequal rib and/or lumbar prominence on one side |
| 5. _____ Uneven scapulae | 6. _____ Curved spine |
| 7. _____ Accentuated round back or hump | |
- Hump Measurement: **Thoracic** ____ inch / ____ degrees; **Lumbar** ____ inch / ____ degrees

TREATING PHYSICIAN'S REPORT

DIAGNOSIS: () Normal
() Positive Findings: () Scoliosis () Kyphosis () Other

TREATMENT: () Observation () Bracing () Surgery () Other

REFERRED TO SPECIALIST: () Yes () No X-RAY ORDERED: () Yes () No

FINDINGS: _____

CIRCLE ONE: Family Physician SIGNED _____ M.D.
Pediatrician
Orthopedist DATE _____

CONSENT FOR RELEASE OF INFORMATION

I agree to release the above information on my child or ward to appropriate health and/or school authorities.

SIGNED _____ DATE _____
(Parent or Guardian)

(SCHOOL LOGO)

PARENTAL NOTIFICATION OF HEAD LICE

Date: _____

Dear Parent,

Please be aware that a student in your child's class has been confirmed to have a lice infestation. Head lice are not a sign of poor hygiene and anyone can get them. Lice do not transmit infections and do not pose a risk to a person's health. Control of head lice depends on timely diagnosis and effective treatment.

Lice can be transmitted from one person to another via direct contact or by sharing clothing with lice on them. Approximately 6 to 12 million children between the ages of 3 and 12 are infested with head lice in the U.S. each year. Common symptoms include:

- Itching - Head lice cause itching, generally at the back of the head or behind the ears. There may be redness or sores that are present due to the scratching.
- Adult Lice on Scalp - The most common spots to find adult head lice are near the back of your neck or behind your ears. Lice are tiny and difficult to see, but they can be up to 1/8 inch in size.
- Visible Nits - Nits are head lice eggs that are tiny, white-colored, round or oval shapes that are attached to the hair near the scalp. They cannot be removed by a normal hair-brush.
- Sleeplessness and Irritability

[Your School Name] follows the Catholic Diocese of Tucson policy which means that any student who has head lice is not allowed to attend school until they have received treatment. Following treatment, a child will be allowed to return to school. Chemical (pediculicide) shampoos kill live lice and are the only known effective treatment. It is essential to re-treat 9 days later or as directed on the shampoo bottle. Chemical shampoos can be purchased over the counter.

If you suspect your child is infested with head lice, the American Academy of Pediatricians (AAP) recommends consulting with your pediatrician or primary care provider for treatment options and guidance. Available treatment options include newly licensed prescription products that are proven safe and effective. The Centers for Disease Control and Prevention (CDC) recommends the following supplemental measures to avoid re-infestation:

- Machine wash and dry clothing, bed linens, and other items that the infested person wore or used during the 2 days before treatment using the hot water (130°F) laundry cycle and the high heat drying cycle. Clothing and items that are not washable can be dry-cleaned.
- Soak combs and brushes in hot water (at least 130°F) for 5-10 minutes
- Vacuum the floor and furniture, particularly where the infected person sat or lay

Spending much time and money on housecleaning activities is not necessary to avoid reinfestation by lice or nits that may have fallen off the head or crawled onto furniture or clothing.

Please note that the Diocese Guidelines and CDC do not recommend mass screenings for head lice. The current policy is to check when students display signs/symptoms such as

- a tickling feeling or a sensation of something moving in the hair
- irritability and sleeplessness
- sores on the head caused by scratching

The rationale is

- Many nits are more than ¼ inch from the scalp. Such nits are usually not viable and very unlikely to hatch to become crawling lice, or may in fact be empty shells, also known as 'casings'.
- Nits are cemented to hair shafts and are very unlikely to be transferred successfully to other people.
- The burden of unnecessary absenteeism to the students, families and communities far outweighs the risks associated with head lice.
- Misdiagnosis of nits is very common during nit checks conducted

Thank you for keeping our children and our school healthy. If you have questions, please contact:

[Name of Health office personnel] in the [School Name] health office at [phone number] or the

Pima County Health Department at 520-724-7770.

Peace and Blessings,

(Name and Title)

(SCHOOL LOGO)

GENERAL HEALTH REFERRAL

Parents/Guardian: Please give this report form to the doctor when your child is examined.

School _____ Date _____

Name _____ Gr. _____ DOB _____

Parent/Guardian _____

Address _____

Reason for referral: _____

Signature of Person Referring

Date

Name (Printed) and Title of Person Referring

FOLLOW-UP HEALTH EXAMINATION

Physician's findings and recommendations: (Please include activity status, whether the student may participate in P.E., length of time if restricted, and any action the school staff should follow for the maximum benefit of the student.)

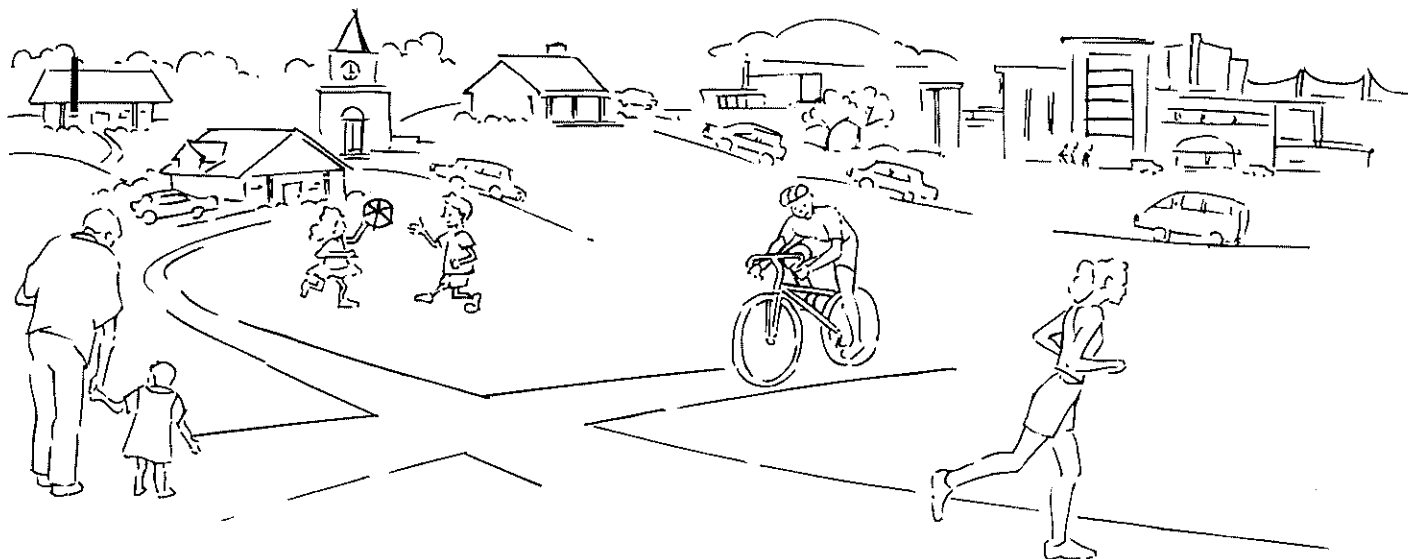
Physician's Name (Printed)

Physician's Signature

Date

PLEASE RETURN THIS DOCUMENT TO SCHOOL.

ASTHMA AND OUTDOOR AIR POLLUTION



1 Air pollution can make asthma symptoms worse and trigger attacks.

If you or your child has asthma, have you ever noticed symptoms get worse when the air is polluted? Air pollution can make it harder to breathe. It can also cause other symptoms, like coughing, wheezing, chest discomfort, and a burning feeling in the lungs.

Two key air pollutants can affect asthma. One is *ozone* (found in smog). The other is *particle pollution* (found in haze, smoke, and dust). When ozone and particle pollution are in the air, adults and children with asthma are more likely to have symptoms.

2 You can take steps to help protect your health from air pollution.

► Get to know how sensitive you are to air pollution.

- Notice your asthma symptoms when you are physically active. Do they happen more often when the air is more polluted? If so, you may be sensitive to air pollution.

- Also notice any asthma symptoms that begin up to a day *after* you have been outdoors in polluted air. Air pollution can make you more sensitive to asthma triggers, like mold and dust mites. If you are more sensitive than usual to indoor asthma triggers, it could be due to air pollution outdoors.

► Know when and where air pollution may be bad.

- *Ozone* is often worst on hot summer days, especially in the afternoons and early evenings.
- *Particle pollution* can be bad any time of year, even in winter. It can be especially bad when the weather is calm, allowing air pollution to build up. Particle levels can also be high:
 - Near busy roads, during rush hour, and around factories.
 - When there is smoke in the air from wood stoves, fireplaces, or burning vegetation.

► **Plan activities when and where pollution levels are lower.** Regular exercise is important for staying healthy, especially for people with asthma. By adjusting when and where you exercise, you can lead a healthy lifestyle and help reduce your asthma symptoms when the air is polluted. In summer, plan your most vigorous activities for the morning. Try to exercise away from busy roads or industrial areas. On hot, smoggy days when ozone levels are high, think about exercising indoors.

► **Change your activity level.** When the air is polluted, try to take it easier if you are active outdoors. This will reduce how much pollution you breathe. Even if you can't change your schedule, you might be able to change your activity so it is less intense. For example, go for a walk instead of a jog. Or, spend less time on the activity. For example, jog for 20 minutes instead of 30.

► **Listen to your body.** If you get asthma symptoms when the air is polluted, stop your activity. Find another, less intense activity.

► **Keep your quick-relief medicine on hand when you're active outdoors.** That way, if you do have symptoms, you'll be prepared. This is especially important if you're starting a new activity that is more intense than you are used to.

► **Consult your health care provider.** If you have asthma symptoms when the air is polluted, talk with your health care provider.

- If you will be exercising more than usual, discuss this with your health care provider. Ask whether you should use medicine before you start outdoor activities.

- If you have symptoms during a certain type of activity, ask your health care provider if you should follow an asthma action plan.

3 Get up-to-date information about your local air quality:

Sometimes you can tell that the air is polluted—for example, on a smoggy or hazy day. But often you can't. In many areas, you can find air quality forecasts and reports on local TV or radio. These reports use the Air Quality Index, or AQI, a simple color scale, to tell you how clean or polluted the air is. You can also find these reports on the Internet at: www.epa.gov/airnow. You can use the AQI to plan your activities each day to help reduce your asthma symptoms.

4 For more information:

Air quality and health:

- EPA's AIRNow website at www.epa.gov/airnow
- Call 1-800-490-9198 to request free EPA brochures on: *Ozone and Your Health*, *Particle Pollution and Your Health*, and *Air Quality Index: A Guide to Air Quality and Your Health*.

Asthma:

- Centers for Disease Control and Prevention (CDC) Web site at www.cdc.gov/asthma

Indoor air and asthma:

- EPA's asthma website at www.epa.gov/asthma



United States
Environmental Protection Agency
EPA-452-F-04-002

Backpack Strategies for Parents and Students

Pack It Light, Wear It Right

Aching back and shoulders...weakened muscles...tingling arms...stooped posture.

Does your child have these symptoms after wearing a heavy school backpack? Carrying too much weight in a pack or wearing it the wrong way can lead to pain and strain. Parents can take steps to help children load and wear backpacks the right way to avoid health problems.

Loading a backpack

Never let a child carry more than 15% of his or her body weight. This means a child who weighs 100 pounds shouldn't wear a loaded school backpack heavier than 15 pounds.

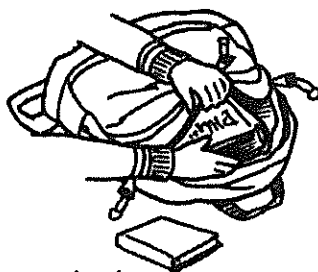
Load heaviest items closest to the child's back (the back of the pack). ►

Arrange books and materials so they won't slide around in the backpack.

Check what your child carries to school and brings home. Make sure the items are necessary to the day's activities.

On days the backpack is too loaded, your child can hand carry a book or other item.

If the backpack is too heavy, consider using a book bag on wheels if your child's school allows it.

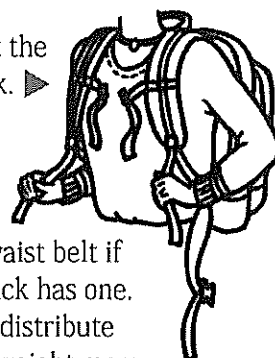


Wearing a backpack

Both shoulder straps should always be worn. Wearing a pack slung over one shoulder can cause a child to lean to one side, curving the spine and causing pain or discomfort.

Select a pack with well-padded shoulder straps. Shoulders and necks have many blood vessels and nerves that can cause pain and tingling in the neck, arms, and hands when too much pressure is applied.

Adjust the shoulder straps so that the pack fits snugly to the child's back. ►
A pack that hangs loosely from the back can pull the child backwards and strain muscles.



◀ Wear the waist belt if the backpack has one. This helps distribute the pack's weight more evenly.

The bottom of the pack should rest in the curve of the lower back. It should never rest

more than four inches below the child's waistline.

School backpacks come in different sizes for different ages. Choose the right size pack for your child's back as well as one with enough room for necessary school items.

Need more information?

If you would like to consult an occupational therapist about an ergonomic evaluation, talk to your child's teacher about whether a referral to occupational therapy is appropriate. Your physician, other health professionals, and your school district's director of special education may also be able to help.

Occupational therapy practitioners are trained in helping children with a broad range of issues in addition to ergonomics, such as good handwriting skills and developmental and behavioral problems, to help them participate more fully in the "occupation" of living. Practitioners work with children in every school district in the nation to improve skills that will help them perform daily tasks at home, at school, and at play.

For more information on occupational therapy, visit www.aota.org.

AOTA

The American
Occupational Therapy
Association, Inc.



Pack It Light, Wear It Right

DIOCESE OF TUCSON CATHOLIC SCHOOLS

SCHOOL HEALTH SERVICES

Cold or Flu Symptoms

Date _____

Your child _____ was seen in the Health Office today for cold or flu symptoms.
Your child's symptoms are circled in the table below.

Colds and flu are caused by viruses and therefore antibiotics are not effective. The following measures are important:

- More sleep and rest is necessary to allow the body to effectively fight the virus.
- Increase fluid intake. Six to eight glasses a day is recommended under normal conditions. A person needs to drink more when they have a cold or flu.
- Eat healthy. This means increasing fruits and vegetables to get the vitamins and minerals needed for good health.
- Warm salt-water gargles are good for a sore throat. Doctors often recommend pain relievers such as acetaminophen or ibuprofen for the aches and pains of a cold or flu. Follow recommended doses carefully!
- Cover coughs and sneezes and wash hands frequently! Research shows that colds and flu are spread from person to person by our hands and by air-borne particles.
- Monitor your child's temperature. If it is 100° or more, call your health care provider, and keep your child home until fever-free for 24 hours without the aid of fever-reducing medications.

Sometimes people are confused about the difference between colds and flu. Here's a comparison of symptoms:

SYMPTOM	COLD	FLU*
FEVER	Fever is uncommon with a cold.	Fever is usually present with the flu. 80% of flu cases include a fever. A temperature of 100° F or higher for 3-4 days is associated with the flu.
ACHES	Slight body aches may be present with a cold.	Severe aches and pains are common with the flu.
CHILLS	Chills are uncommon with a cold.	Chills are fairly common in most flu cases. 60% of flu cases include chills. Chills and shivering are a normal reaction to a cold environment, but unexplained chills can also be a sign of the flu.
TIREDFNESS	Tiredness is mild with a cold.	Tiredness is moderate to severe with the flu. It's normal to feel tired at the end of a long day or when you don't get adequate sleep, but unexplained tiredness can be a sign of the flu.
SUDDEN SYMPTOMS	Cold symptoms are gradual and develop over a few days.	The flu has a rapid onset within 3-6 hours. The flu hits hard and includes sudden symptoms like high fever, aches, and pains.
COUGHING	A hacking, productive (with mucus) cough is often present with a cold.	A nonproductive cough that does not produce mucus is usually present with the flu. Dry cough is present in 80% of flu cases.
SNEEZING	Sneezing is common with a cold.	Sneezing is not commonly present with the flu.
STUFFY NOSE	A stuffy nose usually accompanies a cold and typically resolves spontaneously within a week.	Stuffy nose is not commonly present with the flu.
SORE THROAT	Sore throat is common with a cold. A sore throat is pain and inflammation in the throat that usually comes with a cold.	A sore throat is not commonly present with the flu.
CHEST DISCOMFORT	Chest discomfort is mild to moderate with a cold.	Chest discomfort is often severe with the flu. Chest discomfort is pain or abnormal sensations that you feel anywhere along the front of your body between your neck and upper abdomen.
HEADACHE	A headache is fairly uncommon with a cold.	A headache is very common with the flu. It is present in 80% of flu cases.

* **Menstruating females who experience symptoms while wearing a tampon should always be aware of the possibility of Toxic Shock Syndrome (TSS), which often causes sudden, severe flu-like symptoms. If this is suspected, it is urgent that you seek health care IMMEDIATELY, as this condition can progress rapidly and even cause death.**

DIOCESE OF TUCSON CATHOLIC SCHOOLS
SCHOOL HEALTH SERVICES

Dental Problem

Date _____

Your child _____ was seen in the health office today with the following dental problems:

- ☐ Toothache
 - ☐ tooth decay noted
 - ☐ no obvious signs of tooth decay

- ☐ Sore gums
 - ☐ red
 - ☐ swollen

- ☐ Tooth trauma
 - ☐ loose tooth
 - ☐ bleeding

A warm salt-water rinse may help to relieve the pain temporarily. It is recommended that you schedule a dental appointment

☐ immediately, ☐ as soon as possible, if the pain continues.

If you need help with a dental referral, please call the school health office.

DIOCESE OF TUCSON CATHOLIC SCHOOLS
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HEAD INJURY INFORMATION

Dear Parent & Teacher: _____ Date: _____

_____ received a head injury at school at _____ o'clock.

Nature of injury: _____

Child DID lose consciousness for _____ minutes. Child DID NOT lose consciousness.

Anyone who has sustained a blow to the head should be carefully observed. If the student exhibits or complains of any of the following symptoms, s/he should be seen by a physician at once.

- AMNESIA/MEMORY LOSS
- BLEEDING or DISCHARGE FROM the EARS
- BLURRED VISION
- CONFUSION, UNUSUAL BEHAVIOR, or DISORIENTATION (Should be oriented as to time, place, and person.)
- CONVULSION
- DISCOLORATION or SWELLING AROUND BOTH EYES or BEHIND ONE or BOTH EARS
- DIZZINESS
- FREQUENT SWALLOWING
- IRREGULAR BREATHING
- NAUSEA or VOMITING
- SEVERE HEADACHE
- UNEQUAL or DILATED PUPILS
- STAGGERING, FALLING, or WALKING STRANGELY

If the child wants to sleep, he should be aroused every half hour and checked. After a blow to the head, there should be no physical activity for the rest of the day and no contact sport for several days to several weeks, depending on the severity of the injury. Occasionally children will display symptoms 7-10 days after a head injury. The type of head injury most often seen by the school nurse is a mild blow to the head with localized pain and minimal swelling. It is rare that a head injury sustained at school is severe enough to manifest the symptoms listed. Loss of consciousness is extremely rare in a school setting.

Please inform the health office regarding your child's condition at the end of this day or first thing in the morning or send a note to the health office.

(MORE INFORMATION ON THE REVERSE SIDE OF THIS SHEET)

WAITING AFTER A CONCUSSION

- "Grade 1 Concussion" - if there is temporary confusion for less than 15 minutes and no loss of consciousness.
- "Grade 2 Concussion" - if mental status is abnormal for longer than 15 minutes, but no loss of consciousness.
- "Grade 3 Concussion" - if there is loss of consciousness for any length of time.

This article explains why, when, and for how long collision and contact sports are to be avoided after a Grade 1, 2, or 3 concussion.

After a concussion, the reason there is risk from further participation in collision sports is because the child and adolescent brain is particularly vulnerable to even small changes in cerebral blood flow, to increases in intracranial pressure, and to hypoxia. These occurrences are normally well-tolerated but after a concussion the brain is less able to respond to any increased energy demands. Brain cells are more likely to die. Minor head injuries in the days after a concussion are far more damaging than minor head injuries at other times.

Recommendations:

- After a Grade 1 concussion, sport participation can be resumed the same day if all symptoms resolve within 15 minutes and do not recur. Otherwise, wait one full week after last symptom.
- After a Grade 2 concussion, disallow sports for one week after the last symptom. If a Grade 1 and Grade 2 concussion occur on the same day, then no sports should be allowed for two weeks after last symptom.
- After a Grade 3 concussion, no sports should be allowed for one week after the last symptom if loss of consciousness lasted seconds, and two weeks if it lasted minutes. If there were two Grade 3 concussions, no sports should be allowed for one month after last symptom.

Students with Grade 2 and 3 concussions often receive CT scans to determine if there are any skull fractures, or if there was a cerebral *contusion* (hemorrhage or bruising under unbroken skin), cerebral *edema* (excessive fluid in the brain tissue), or intracranial hemorrhage. A normal CT scan, however, does not provide information about microscopic injury to neuronal cells. A normal CT scan is inadequate for allowing early re-entry to sports. Children with abnormalities on a CT or MRI should be discouraged from all further participation in contact sports.

(Bowen, AP. *J of Emerg Nurs* 2003; 29(3):287-289.)

DIOCESE OF TUCSON CATHOLIC SCHOOLS SCHOOL HEALTH SERVICES

Parent Information on Treating Head Lice

In the past few years there has been a nationwide increase in the incidence of head lice. Many questions that may arise concerning the treatments for head lice are answered in the following information. If you have any questions regarding this information, please call your school nurse or health office staff member.

Head Lice Can Happen to Anyone! It is NOT a sign of poor health habits or being dirty, nor do lice prefer a particular economic, racial, or ethnic group. It can happen to you! Therefore, it is best to learn to recognize, treat, and prevent head lice infestation.

How Do You Get Head Lice? They are transmitted primarily by head to head contact, which explains why head lice are found more frequently in groups of younger children and family members. Head lice may also be passed from person to person on shared objects like combs, brushes, hair ties, hats, coats, and back packs, and on furniture like car seats and high-backed chairs. Shared towels, bedding, stuffed animals, and clothing can also spread head lice.

What is Fact? Head lice only live on humans, not any other animal; and they will not survive more than three days without a human host for a blood meal. They do not jump, and they do not have wings or fly.

What Are Some Signs of Head Lice? Persistent itching of the back of the neck and head may indicate head lice. Adult lice are not always seen because they move quickly to hide next to the scalp and there are usually few of them. The most important sign is the nits (eggs) which can be found attached to individual hair shafts, close to the scalp, especially at the nape of the neck and behind the ears. They are very small, white oval specks which can sometimes be confused with dandruff. Unlike dandruff, nits need to be pulled down the entire shaft of hair to be removed; they cannot just be brushed aside.

How Can Lice Be Treated? Once lice are found, treatment should be prompt to prevent spreading to others. There are various treatment choices:

Medicated lice treatments may be used, but the directions on the box must be followed exactly. For example, most of the medicated shampoos require you to apply the product directly to dry hair and leave in place for a specified amount of time before washing it out. Some experts recommend not using conditioner if the hair is shampooed prior to the lice treatment. No matter which product you use, do not apply while the child is in the tub or shower. Use the medication over a sink and keep eyes covered with a washcloth. Consult your doctor if you are pregnant, nursing, or allergic to ragweed. Never use the chemicals on a baby. Again, read the directions that come with the product carefully. After using the lice treatment, use the fine-tooth comb included with the product to remove nits (eggs). Any remaining nits must be removed with your fingers if necessary.

What Else Needs To Be Done?

1. All family members should be examined and treated on the same day if lice or nits are found.
2. All articles that may contain lice or nits such as clothes, towels, and bed linens should be washed in hot water (130 degrees F or more) and detergent and dried in a hot dryer for at least 20 minutes.
3. Items not machine washed can be dry cleaned. Another suggestion is to place non-washable items in a dark plastic bag and set out in the sun for several hours or keep sealed tightly for 10 days.
4. Combs and brushes can be soaked in bleach solution or placed in very hot water for at least 10 minutes.
5. Thoroughly vacuum carpets and upholstered furniture. Commercial spray products for furniture and carpets are **NOT** recommended, as they are harmful pesticides.

What Is The Procedure At School? When a child is found to have an active case of head lice, parents will be contacted, and the child needs to begin treatment as soon as s/he gets home from school. When the child returns the following school day, he or she should be examined by the school nurse before returning to the classroom and the nurse will need a note or parent visit to relate information about the treatment used. The nurse will periodically re-check the child for possible re-infestations. All opportunities are taken by the nurse to educate teachers, parents and students in the classrooms. Parents are encouraged to make checking for head lice a part of routine hygiene, just like brushing one's teeth.

The following website is also a helpful resource: <https://www.headlice.org/>.

DIOCESE OF TUCSON CATHOLIC SCHOOLS
SCHOOL HEALTH SERVICES

Impetigo

Date _____

Your child _____ was seen in the health office today for possible impetigo. Lesions were observed on _____.

() Infectious lesions were completely covered with a bandage.

() Schedule an appointment with a health care provider for diagnosis and treatment.

Impetigo is a contagious skin infection caused by bacteria. The bacteria enter the skin through a scratch, cut, or insect bite. The lesion formed is covered with a brownish yellow (honey-colored) crust. Lesions can spread to other parts of the body or to other persons by direct contact with the sores or by hands that have touched them. Scratching causes the lesions to spread.

Preschool students may not attend school until 24 hours after beginning oral antibiotic treatment or 48 hours after starting antibiotic ointment prescribed by the health care provider.

Students in kindergarten and older may attend school IF they only have a few sores and IF the sores can be completely covered with a bandage. Without treatment, impetigo will continue to spread.

A student with several lesions must see a health care provider for diagnosis and treatment. In the meantime, treat the lesions by soaking the area with water and removing the crust. A topical antibiotic ointment should be applied to each sore.

Wash hands with soap and water after touching the sore. Discard any tissues, paper towels or bandages that have come into contact with the sore. Your child should not share towels or washcloths with anyone else in the household.

If you have questions, call the school health office.

DIOCESE OF TUCSON CATHOLIC SCHOOLS
SCHOOL HEALTH SERVICES

Mouth Sores

Date _____

Your child _____ was seen in the health office today with one of the following mouth sores:

() Cold sore, also known as a fever blister

() Canker sore

Both of the above can be uncomfortable or painful.

Cold sores are common and usually occur around the lips and nose. The sore usually heals in 6-10 days, but the virus and sore may return later. Sunlight, fever, menstruation, physical or emotional stress can be the cause. Symptoms begin with a burning, tingling or itching sensation. They are contagious only when the lesions are present on the skin and are transmitted by direct contact with infected saliva or the lesion itself.

Canker sores are small white spots surrounded by redness, found on the gums, inner parts of the lips, cheeks, or tongue.

Students may come to school with either cold sores or canker sores. They are caused by viruses and heal by themselves. Careful, frequent hand washing and using disposable or paper towels to dry the area, will help reduce the possibility of transferring cold sores to other parts of the body or to other people. Those who wear contact lenses must wash hands carefully to avoid transmitting the virus to their eyes.

Children may not want to eat when they have painful mouth lesions. Ensure adequate fluid intake during the painful period. Warm, mild salt-water rinses, cold liquids, popsicles or frozen juices are helpful.

There is no cure for cold sores or canker sores. Consult your pharmacist for recommended over-the-counter pain relief agents. Severe cases may benefit from anti-viral medication which must be prescribed by your health care provider.

DIOCESE OF TUCSON CATHOLIC SCHOOLS
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Pinkeye

Date _____

Your child _____ was seen in the health office today for possible pinkeye. The following conditions were observed:

- () reddened whites of the eyes
- () swelling, burning
- () stringy yellow mucous which is hard to remove
- () feels like something is in the eye

Pinkeye (Conjunctivitis) is an inflammation of the membrane that lines the eye and the inner surface of the eyelids. It can be caused by bacteria or a virus. It is highly contagious. Remind students to wash hands often, especially after touching the face and eyes. At home, the child should not share towels or washcloths with the rest of the family until the eyes have cleared up.

See a health care provider as soon as possible. If s/he diagnoses a bacterial conjunctivitis, it is required that your child be excluded from school until antibiotic therapy is initiated and maintained for at least 24 hours. However, if the doctor determines that the conjunctivitis is viral or allergic in origin, please have him/her write a note to the school indicating that the child is cleared to return right away.

If you have questions, call the school health office.

DIOCESE OF TUCSON CATHOLIC SCHOOLS
SCHOOL HEALTH SERVICES

Sore Throat

Date _____

Your child _____ was seen in the health office today for a sore throat.
The following conditions were observed:

- | | |
|---------------------------|---|
| () Temperature was _____ | () White spots in throat |
| () Difficulty swallowing | () Swollen tonsils |
| () Red throat | () Complaint of headache and/or stomach ache |

Sore throats can be caused by allergies, viruses, or bacteria.

Those caused by viruses can be treated at home. Acetaminophen (Tylenol) or ibuprofen (Advil/Motrin) are often recommended by doctors for mild pain relief. Cold liquids, warm salt-water gargle, and honey or lemon in tea are helpful for the pain.

Those caused by bacteria called Strep must be treated by antibiotics. A throat culture done by a health care provider is the only way to determine if a sore throat is caused by Strep. Serious complications including kidney problems and rheumatic fever can occur if Strep infections are not treated with antibiotics. Strep throat is often accompanied by a headache and/or upset stomach.

Please seek medical assistance if the sore throat had a sudden onset and persists, if there are no cold symptoms such as cough, or runny nose associated with it, if a rash accompanies it, if your child's temperature is 101 degrees or above, or if there is a serious difficulty swallowing.

If your health care provider diagnoses Strep throat, please notify the school right away and keep your child home until s/he has been on antibiotics at least 24 hours and is feeling well enough to return to school.

If you have any questions, please call the school health office.

DIOCESE OF TUCSON CATHOLIC SCHOOLS
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Stomach Ache

Date: _____

Your child _____ was seen in the health office today for a stomach ache at _____ (time). His/her temperature was _____ degrees. S/he complains of the following symptoms:

_____ nausea	_____ overheated
_____ vomiting	_____ cramping
_____ abdominal burning	_____ exercised heavily after eating
_____ sharp pains	_____ premenstrual discomfort
_____ dull ache	_____ stress, anxiety
_____ diarrhea	_____ sore throat
_____ constipation	_____ allergies
_____ hunger	_____ other: _____

The nurse/health aide implemented the following interventions:

_____ rest	_____ referred to school counselor
_____ used bathroom; relief obtained	_____ other: _____
_____ given food/snack	

There can be many causes for stomach aches, including hunger, overeating, gas, indigestion, constipation, food poisoning, intestinal infections, allergies, stress, anxiety, and appendicitis. The condition is often minor, needs no special treatment, and goes away by itself.

The following conditions may require calling a health professional.

- Stomach pain that is severe or persistent, increases over several hours or localizes to one area of the abdomen.
- Diarrhea that is accompanied by fever of 101 degrees or higher, dry mouth, cracked lips (indicating dehydration), or is severe (loose stools every 1-2 hours).
 - + To prevent dehydration take frequent small sips of water.
 - + To stop diarrhea, stop all food for several hours.
 - + As diarrhea subsides, begin the **BRAT** diet: **B**ananas, **R**ice, **A**pplesauce, and **T**oast, in small quantities.
 - + May resume eating a normal, well-balanced, age-appropriate diet within 24 hours of getting sick.
- Vomiting that is severe, frequent or violent, contains blood, occurs with fever above 101 degrees, or with increasing pain in the lower right abdomen.
 - + When vomiting, stop all food for several hours.
 - + Take frequent small sips of water.
 - + Drink only clear liquids for the next 12-24 hours.
 - + Then begin eating clear soups, jello, toast, crackers, or cooked cereal until all symptoms are gone for 12-48 hours.
- Fever 101 degrees or above accompanied by right sided lower abdominal pain and tenderness that gets worse. Symptoms suggest possible appendicitis.

If you have any questions, please call the school health office.

DIOCESE OF TUCSON CATHOLIC SCHOOLS
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Strain/Sprain

Date _____

Your child _____ was seen in the health office today for a strain or simple sprain injury. A description of the injury follows:

- () Ice was applied for 15-20 minutes.
- () Ace wrap or splint applied to injured part.
- () Student rested injured area.
- () Injured area was elevated throughout the day, when possible.

At home please continue care as follows:

R = Rest

Rest the injured part until pain and swelling subside. This means: NO sports, P.E., games, and other load-bearing activities

I = Ice

Ice the injured part, every 3-4 hours for the first 24 hours, for approximately 15-20 minutes each time.

C = Compression

Compress the injured part to provide support with an "ace wrap" or elastic bandage, or a splint or brace. Do not wrap too tightly and remove the wrap before going to bed.

E = Elevation

Elevate the injured part to decrease or eliminate swelling.

****If there is no improvement after 24 hours of "RICE" treatment or you notice increased pain, swelling, bruising, and/or decreasing ability to move the injured part: CALL YOUR HEALTH CARE PROVIDER!**

If you have any questions, call the school health office.

DIOCESE OF TUCSON CATHOLIC SCHOOLS
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Sty

Date _____

Your child, _____, was seen in the health office today for a possible sty. A red bump was observed where the lashes go into the skin. A sty is usually painful and tender.

A sty is caused by inflammation of the oil glands of the eyelids. It is an abscess that grows to full size in a day. The eyeball itself is not involved and vision problems are unrelated.

Home Treatment

Treat with a warm, moist compress (washcloth) for 10 to 15 minutes, three times a day.

If there is no improvement within 48 hours, call your health care provider.

If you have any questions, call the school health office.

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Urinary Tract Infection

Date: _____

Your child _____ was seen in the health office today for indications of a possible urinary tract infection (UTI). She/he reported the following symptoms:

- () Pain or burning with urination
- () Frequent urge to urinate without being able to pass much urine
- () Blood and/or pus noted in urine or in underwear
- () Pain in the lower abdomen
- () Fever and/or chills

UTI's are infections that are caused by bacteria entering the bladder. Symptoms include the items listed above. If painful elimination is accompanied by any of the items, call a health professional for diagnosis and treatment.

To prevent UTI's:

- Drink more fluids; 8 – 10 glasses of water/day; diluted cranberry juice is often recommended.
- Urinate frequently.
- Females should always wipe from front to back, especially following bowel movements to prevent the spread of bacteria.
- Avoid bubble baths, vaginal deodorants, frequent douching, perfumed hygiene products.
- Wear cotton underwear (not thongs), and loose clothing.

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Wounds

Date _____

Your child, _____, was seen in the health office today for a wound received () at school () at home. A description of the wound as described by the student follows:

The wound was cleansed, and a bandage was applied.

() There are some signs of infection and it is recommended that you seek further medical care right away.

() The wound does not appear infected at this time. At home please continue care:

- Keep area clean, using soap and water at least once a day.
- Keep the wound covered until a scab has formed but do change the bandage and cleanse wound daily until healed.
- Do not touch the area without washing your hands first!
- Hydrogen peroxide is not recommended for cleaning a wound as it can slow the healing process. Simple soap and water are adequate.
- If your child has not had a Tetanus shot within the last 5 years you should take him/her to your health care provider for a booster. Our records show your child's last Tetanus shot was on _____.
- If you are noticing signs of infection (pain, swelling, heat, redness, or pus), SOAK the wound in a basin of very warm water or APPLY A WARM, WET CLOTH--as warm as can be tolerated--for about 10 minutes, then dry and cover with a clean bandage. Repeat every 3-4 hours. If there is no improvement within 8-12 hours or it appears to be getting worse, CALL YOUR HEALTH CARE PROVIDER!

If you have any questions, call the school health office.

School:		Date:
Student Name:		DOB:
When, where, how injury incurred, plus complaints, Re: pain & function:		
Time of Incident:	Arrival in Health Office:	Departure:
Signature:		Title:

EYE INJURY

REPORT OF CUT OR BLOW TO EYE				REPORT OF CHEMICAL SPLASHED IN EYE			
ASSESS SIGNS & SYMPTOMS				INTERVENE			
Eye Injured: <i>WITHOUT TOUCHING, INSPECT EYE.</i>	BOTH	RIGHT	LEFT	Eye Splashed:	BOTH	RIGHT	LEFT
Appears cut or ruptured?		YES	NO	• Flush from nose outward with lukewarm tap water by placing face under tap with eye open or pouring from container.			
Shape of eyeball "squashed" or abnormal?		YES	NO	• Instruct student to move eye and open & close lids repeatedly to aid flushing.			
Iris cloudy or bloody?		YES	NO	• Pull eyelashes forward to allow water to flow under lid.			
Blood over sclera?		YES	NO	• Determine chemical involved.			
Pupil abnormal shape?		YES	NO	• Consult AZ Poison Control Center (1-800-222-1222.)			
Sharp object imbedded in eye?		YES	NO	• Continue flushing at least 10 minutes.			
Eyelid cut or lacerated?		YES	NO				
Unable to open eye (after calm)?		YES	NO				

NO CONTINUE ASSESSMENT			YES TO ANY INTERVENE			ASSESS													
Eye does not move well in all directions?	YES	NO	<ul style="list-style-type: none"> • Have lie quietly on back. • Never attempt to remove imbedded object. • Protect injured eye with shield or disposable cup inverted & taped securely. <u>Apply no pressure to eyeball.</u> • Call Nurse-Time: _____ • Call Parents-Time: _____ • Refer to doctor immediately. • Send documentation with student for doctor, including date of last Td. • Follow up for Dx & Rx info. 	Was chemical corrosive (acid/alkali)?	YES	NO	<table border="1"> <tr> <td></td> <td>BEFORE INJURY</td> <td>AFTER INJURY</td> </tr> <tr> <td>BOTH</td> <td></td> <td></td> </tr> <tr> <td>RIGHT</td> <td></td> <td></td> </tr> <tr> <td>LEFT</td> <td></td> <td></td> </tr> </table>		BEFORE INJURY	AFTER INJURY	BOTH			RIGHT			LEFT		
	BEFORE INJURY	AFTER INJURY																	
BOTH																			
RIGHT																			
LEFT																			
Movement of eye causes pain?	YES	NO	Persistent pain, tearing, blinking?	YES	NO														
Visual change (either reported by student or detected by screening)?	YES	NO	Mark or cloudy spot on iris?	YES	NO														
			Vision blurred?	YES	NO														

NO CONTINUE ASSESSMENT			YES TO ANY INTERVENE			NO INTERVENE			YES TO ANY INTERVENE		
Eye struck by fast moving blunt object (fist or ball), projectile (metal/stone chip), vegetative matter, or sharp object?	YES	NO	<ul style="list-style-type: none"> • Have lie quietly on back. • Protect injured eye with shield or disposable cup inverted & taped securely. <u>Apply no pressure to eyeball.</u> • Call Nurse-Time: _____ • Call Parents-Time: _____ • Refer to doctor immediately. • Send documentation with student for doctor, including date of last Td. • Follow up for Dx & Rx info. 	<ul style="list-style-type: none"> • Call parents-Time: _____ • Send back to class. • Recheck later in day. 	<ul style="list-style-type: none"> • Call Nurse-Time: _____ • Call parents-Time: _____ • Refer to doctor. • Send documentation with student for doctor. • Follow up for Dx & Rx info. 						
More than slight tenderness of bones around eye?	YES	NO									
Eyelid droops?	YES	NO									
Pain in or behind eyeball?	YES	NO									
Sensitive to light?	YES	NO									
Bruising of sclera (usually bright red)?	YES	NO									
Wearing contact lens when injured?	YES	NO									

NO INTERVENE		YES TO ANY INTERVENE	
<ul style="list-style-type: none"> • Call or write parents-Time: _____ • Send back to class. • Recheck later in day or next day. 	<ul style="list-style-type: none"> • Call Nurse-Time: _____ • Call parents-Time: _____ • Refer to doctor immediately. • Send documentation with student for doctor. • Follow up for Dx & Rx info. 		

COMMENT: If shock assessment needed, use SHOCK assessment sheet or reverse side of this sheet.

School: _____		Date: _____
Student Name: _____		DOB: _____
When, where, how injury incurred, plus complaints, Re: pain & function: _____		
Time of Incident: _____	Arrival in Health Office: _____	Departure: _____
Signature: _____		Title: _____

FRACTURES, DISLOCATIONS, STRAINS, SPRAINS, CONTUSIONS

Record assessments & interventions by circling YES, NO, & intervention done, plus filling in blanks.

ASSESS SIGNS & SYMPTOMS		
Time: _____ Pulse: _____ BP: _____	Localized pain & tenderness? YES NO Where? _____ Swelling? YES NO Discoloration? YES NO Guarding: limitation of motion/function? YES NO	

↓

IF YES TO ANY ABOVE CONTINUE ASSESSMENT
--

↓

Injury caused by blow to muscle? YES NO
--

↓

NO
STRAIN

YES
CONTUSION

Deformed appearance? YES NO Jarring intolerable? YES NO Report of crepitus? YES NO Hx indicative of Fx? YES NO Distal to injury, quality altered of: Pulses? YES NO Capillary Refill? YES NO Sensation? YES NO Skin Temperature? YES NO Skin Color? YES NO	
---	--

↓

NO
SPRAIN

YES TO ANY
MAY BE Fx/DISLOCATION

↓

Deep laceration &/or exposed bone? YES NO

↓

INTERVENE	NO INTERVENE	YES INTERVENE
<ul style="list-style-type: none"> Rest. Ice. Compression by ace wrap. Elevation of part above heart level. Call parents-Time: _____ Refer to doctor if extreme swelling, discoloration, or abnormal muscle contour. Follow up until resolved. If not referred to doctor initially & recuperation seems long, refer. 	<ul style="list-style-type: none"> Call nurse & parents-Time: _____ Immobilize joints above & below injury. Recheck circulation. Elevate above heart if possible. Apply cold. Refer to doctor. Send documentation with student for doctor. Follow up for Dx & Rx info. 	<ul style="list-style-type: none"> Call nurse & parents-Time: _____ Control bleeding. Cover bone & wound with dressing. Immobilize joints above & below injury. Do not elevate. Recheck circulation. Refer to doctor. Send documentation with student for doctor, including date of last Td. Follow up for Dx & Rx info.

COMMENT: If shock assessment needed, use SHOCK sheet or reverse side of this sheet.

School:		Date:	
Student Name:		DOB:	
When, where, how injury incurred, plus complaints, Re: pain & function:			
Time of Incident:		Arrival in Health Office:	
Signature:		Title:	

HEAD INJURY

Record assessments & interventions by circling YES, NO, & intervention done, plus filling in blanks.

GLASGOW COMA SCALE		Initial	5 Min	30 Min	60 Min
1. BEST EYE OPENING					
Spontaneous	4				
To Voice	3				
To Pain	2				
None	1				
Swollen Shut	S				
2. BEST VERBAL RESPONSE*					
Oriented	5				
Confused	4				
Inappropriate Words	3				
Incomprehensible Sounds	2				
None	1				
3. BEST MOTOR RESPONSE					
Obeys Commands	6				
Localizes Pain	5				
Withdraws to Pain	4				
Flexes to Pain	3				
Extends to Pain	2				
None	1				
GLASGOW COMA TOTAL					
PUPILS		Initial	5 Min	30 Min	60 Min
RIGHT	SIZE				
	RESPONSE				
LEFT	SIZE				
	RESPONSE				

PUPILARY RESPONSE	
1 •	C Constricted
2 •	D Dilated
3 •	E Equal
4 •	F Fixed
5 •	NR Nonreactive
6 •	R Reactive
7 •	S Sluggish
8 •	U Unequal
9 •	

A person with significant head injury is always at high risk for a spinal injury. Always take spinal precautions if a person is down with a head injury.

Time: _____

Airway obstructed? YES NO

Abnormal breathing pattern/rate? YES NO R: _____

Abnormal pulse? YES NO P: _____

Abnormal skull contour? YES NO

Describe: _____

Abnormal reflexes? YES NO

Describe: _____

Hand grips unequal in strength? YES NO

Describe: _____

***PRE-VERBAL:**

- 5 Smiles, coos, cries appropriately
- 4 Cries
- 3 Inappropriate crying and/or screaming
- 2 Grunts
- 1 None

NO TO ALL & GCS = 15 CONTINUE ASSESSMENT

YES TO ANY OR GCS BELOW 15 INTERVENE
<ul style="list-style-type: none"> Call nurse-Time: _____ Nurse will decide whether to call 911 or wait for her assessment. Call parents-Time: _____ Refer to doctor and send documentation with student. Follow up for Dx & Rx info.

BLEEDING YES NO	SWELLING YES NO
---------------------------	---------------------------

IF YES INTERVENE
<ul style="list-style-type: none"> Do NOT remove imbedded object. Apply pressure to bleeding unless depressed Fx suspected, then just to edges. Laceration may require sutures? YES NO Call Nurse - Time: _____ Call parents - Time: _____ Nurse will decide whether to ask parents to transport to doctor or to call 911. Send documentation with student for doctor, including date of last Td. Follow up for Dx & Rx info.

WHETHER YES OR NO INTERVENE
<ul style="list-style-type: none"> Apply ice. Observe 20 - 30 minutes.

CONTINUE ASSESSMENT		
Repeat initial assessment. Time: _____	BP: _____	P: _____
Abnormal behavior?	YES	NO
Distorted memory at incident?	YES	NO
Vision blurred?	YES	NO
Sees double?	YES	NO
Eyes fail to move together?	YES	NO
Fluid leakage/bleeding from nose/ears?	YES	NO
Very severe headaches?	YES	NO
Dizziness?	YES	NO
Seizure?	YES	NO
Neck pain?	YES	NO
Mobility of arms/legs altered?	YES	NO
Vomited more than twice?	YES	NO

NO INTERVENE	YES TO ANY INTERVENE
-------------------------------	---------------------------------------

- COMMENTS: If shock assessment needed, use SHOCK assessment sheet or back of this sheet. If assessment done after a period of elapsed time, be alert to the following signs of serious head injury:
- CUSHING'S TRIAD - Increased systolic BP, decreased heart rate, widened pulse pressure. Is a sign of increased intracranial pressure.
 - RACCOON EYES - Discoloration & swelling around both eyes. Suggests basilar skull Fx or facial RC.
 - BATTLE'S SIGN - Discoloration & swelling behind one or both ears. Suggests basilar skull Fx.

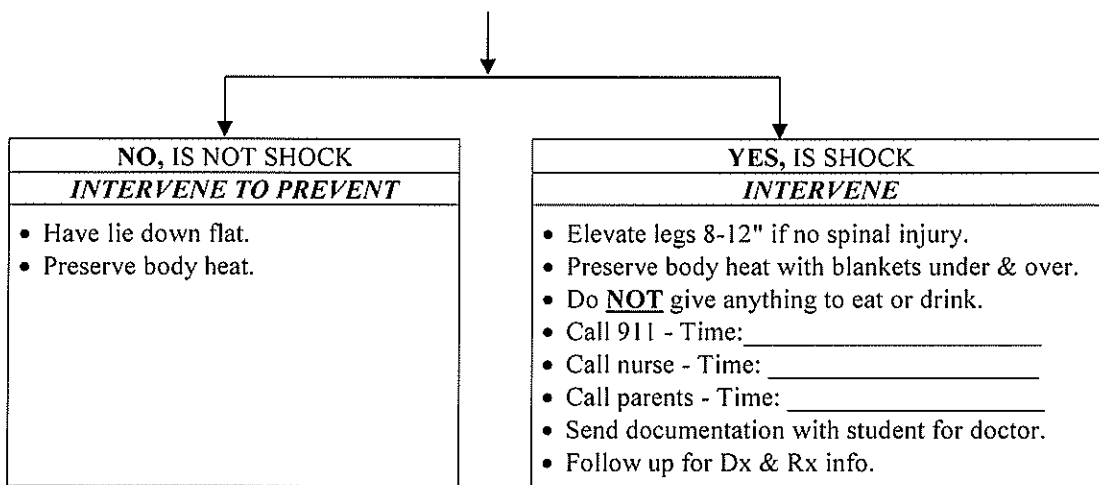
<ul style="list-style-type: none">• Call parents-Time:_____• Send head injury note home.• Send back to class.• Recheck later in day.	<ul style="list-style-type: none">• Call nurse-Time:_____• Call parents-Time:_____• Nurse will decide whether to ask parents to transport to doctor or to call 911.• Send documentation with student for doctor.
---	---

School:		Date:
Student Name:		DOB:
When, where, how injury incurred, plus complaints, Re: pain & function:		
Time of Incident:	Arrival in Health Office:	Departure:
Signature:		Title:

SHOCK

Record assessments & interventions by circling YES, NO, & intervention done, plus filling in blanks.





<i>ASSESS SIGNS & SYMPTOMS</i>									
Rapid Breathing?	YES	NO	TIME						
Rapid/weak pulse?	YES	NO							
Decreased BP?	YES	NO							
Restless or irritable?	YES	NO	RESP						
Pale/bluish, cool, moist skin?	YES	NO							
Slow capillary filling time?	YES	NO							
Heavy sweating?	YES	NO	PULSE						
Dilated pupils?	YES	NO							
Dull, sunken look to eyes?	YES	NO							
Excessive thirst?	YES	NO	BP						
Nausea/vomiting?	YES	NO							
Drowsiness/loss of consciousness?	YES	NO							



SUSPECTED SUBSTANCE ABUSE - PHYSICAL ASSESSMENT CHECKLIST

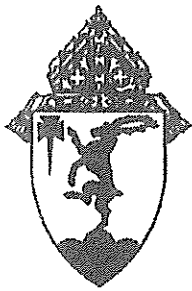
School:	Date:	Time:
Student Name:	DOB:	
Address:	Ph (h):	Ph (w):

SUBJECTIVE		
How do you feel?		
Are you ill?		
Are you diabetic?	Do you take insulin?	Do you have epilepsy?
Have you ever had a head injury?	If yes, explain:	
When did you last eat?	What did you eat?	
How much sleep in past 24 hours?	When did you wake up?	
Are you on any medication?	Name of medication:	
Have you taken any drugs?	What kind?	
If you took a drug test today, would you pass it?		
Do you know why you have been referred to the health office?		

OBJECTIVE	NORMAL RANGE
Pulse:	60-90
Blood Pressure:	120-140 / 70-90
Respiration:	12 - 15
Temperature:	98.6° F ± 1°
Pupils:	React to Light
Pupil Size:	3.0 - 6.5 (millimeters)
Conjunctiva:	1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 5.5 6.0
Odor:	
Behavior: (Circle all that apply.) <div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;">anxious</div> <div style="width: 50%;">euphoric</div> <div style="width: 50%;">excited</div> <div style="width: 50%;">confused</div> <div style="width: 50%;">disoriented</div> <div style="width: 50%;">irritable</div> <div style="width: 50%;">restless</div> <div style="width: 50%;">alert</div> <div style="width: 50%;">sluggish</div> <div style="width: 50%;">combative</div> <div style="width: 50%;">stuporous</div> <div style="width: 50%;">oriented</div> <div style="width: 50%;">cooperative</div> </div>	
	9.0 8.5 8.0 7.5 7.0 6.5 S.A.F.E. Substance Abuse Free Environment Substance Abuse Identification Programs
Internal Clock Estimation:	30 Seconds
Body Tremors _____ Eyelid Tremors _____ HGN _____ VGN _____ (Horizontal gaze nystagmus) (Vertical gaze nystagmus)	Sway  
Modified Romberg:	
Comments:	

See the back of this form and circle any indicators you have noted.

Observer's signature and title: _____



Diocese of Tucson

Department of Catholic Schools

64 E. Broadway Blvd. Tucson, Arizona 85701 • 520.838.2500
FAX (520) 838-2589 • cathsch@diocesetucson.org

ACCIDENT REPORT

This accident report is to be completed for ALL incidents requiring a doctor visit whether or not the parent files an insurance claim through the school. File this report in the student's permanent school record.

Name of School: _____

Person Completing Report: _____ Phone: _____

Date of Accident: _____ Time: _____ AM ___ PM ___

Location of Accident: _____

Student's Name: _____ Age & DOB: _____

Address: _____ Phone: _____

Parent's Name: _____

Parent's Employer: _____

Parent's Medical Insurance Co.: _____

Doctor Treating This Incident:

Name: _____ Phone: _____

Address: _____

Was anyone else involved in the accident? Yes _____ No _____

Name of that person: _____ Phone: _____

Name and relationship to student of person who picked up student:

Nature or description of the injury (use reverse if necessary): _____

Were paramedics called? _____ If "Yes", attach copy of paramedic reporting documentation.

Witnesses to the Accident:

Name: _____ Phone: _____

SEE REVERSE SIDE FOR CLAIM FILING INSTRUCTIONS



1. Report school related injuries to the school within 72 hours.
2. Complete this form.
3. Attach all bills
4. Mail to:



myers • stevens & toohey & co., inc.
 26101 marguerite parkway
 mission viejo, california 92692-3203
 (949) 348-0656 • fax (949) 348-2630



**DIOCESE
 ACCIDENT CLAIM FORM**
 PLEASE PRINT OR TYPE CLEARLY
 Beech Street Corporation

PART A SCHOOL/CHURCH STATEMENT (PARENT MAY COMPLETE PART A IF INJURY IS NOT SCHOOL RELATED)

NAME OF INSURED PERSON FIRST MI LAST				STUDENT SOCIAL SECURITY #		STUDENT I.D. # FROM I.D. CARD	
NAME OF SCHOOL/CHURCH				AGE	GRADE	<input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	DATE OF BIRTH MO / DAY / YR
ADDRESS OF SCHOOL/CHURCH				CITY		STATE	ZIP CODE
DATE OF INJURY MO / DAY / YR		TIME OF INJURY : A.M. / P.M. (CIRCLE ONE)		INJURY OCCURRED: <input type="checkbox"/> PRACTICE <input type="checkbox"/> GAME <input type="checkbox"/> P.E. <input type="checkbox"/> CLASSROOM <input type="checkbox"/> TRAVEL PLEASE ✓ ONE <input type="checkbox"/> AT HOME <input type="checkbox"/> INTERSCHOLASTIC SPORT <input type="checkbox"/> OTHER <input type="checkbox"/> FIELD TRIP			TYPE OF SPORT
DETAILS ON HOW THE INJURY OCCURRED, PLEASE BE SPECIFIC (NOTE: IF YOUR SCHOOL USES AN ACCIDENT REPORT FORM, PLEASE ATTACH A COPY OF THE REPORT ALSO).				WAS STUDENT PARTICIPATING IN SPORT NOT SCHOOL-RELATED? (IF YES, LIST NAME AND PHONE NO. OF GROUP) <input type="checkbox"/> YES <input type="checkbox"/> NO			
WHAT PART OF THE BODY WAS INJURED?		HAS THE STUDENT SUFFERED FROM SAME OR SIMILAR CONDITION BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, WHEN?					
INDICATE IF INJURY WAS RECEIVED DURING PARTICIPATION IN THE FOLLOWING ACTIVITIES, PLEASE CHECK THE APPROPRIATE BOX: <input type="checkbox"/> SCHOOL <input type="checkbox"/> C.C.D. <input type="checkbox"/> YOUTH MINISTRIES <input type="checkbox"/> YOUNG ADULT MINISTRIES <input type="checkbox"/> CYO OTHER <input type="checkbox"/> OTHER							
NAME OF SUPERVISOR		DATE SCHOOL/CHURCH WAS NOTIFIED OF ACCIDENT		WAS HE/SHE A WITNESS TO THE ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			
NAME OF SCHOOL/CHURCH OFFICIAL		SIGNATURE OF SCHOOL/CHURCH OFFICIAL X		DATE SIGNED		SCHOOL/CHURCH TELEPHONE NO. ()	
NAME, ADDRESS AND PHONE # OF INSURED'S FAMILY PHYSICIAN				CITY		STATE	ZIP CODE PHONE #

PART B PARENT OR GUARDIAN STATEMENT

RELATIONSHIP TO INJURED <input type="checkbox"/> FATHER <input type="checkbox"/> MOTHER <input type="checkbox"/> GUARDIAN <input type="checkbox"/> OTHER		IS THIS DEPENDENT COVERED BY OTHER HEALTH AND/OR ACCIDENT INSURANCE PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO	
NAME OF FATHER OR MALE GUARDIAN		S.S. # OF FATHER OR MALE GUARDIAN	
ADDRESS		HOME TELEPHONE NO. ()	
CITY		STATE ZIP CODE	
NAME OF EMPLOYER		WORK TELEPHONE AND EXTENSION NO. ()	
ADDRESS OF EMPLOYER		CITY STATE ZIP CODE	
NAME OF OTHER HEALTH AND/OR ACCIDENT INSURANCE COMPANY THROUGH FATHER OR MALE GUARDIAN		POLICY NUMBER	
ADDRESS OF INSURANCE COMPANY		TELEPHONE NO. ()	
CITY		STATE ZIP CODE	
NAME OF (MOTHER OR FEMALE GUARDIAN)		S.S. # OF MOTHER OR FEMALE GUARDIAN	
ADDRESS		HOME TELEPHONE NO. ()	
CITY		STATE ZIP CODE	
NAME OF EMPLOYER		WORK TELEPHONE AND EXTENSION NO. ()	
ADDRESS OF EMPLOYER		CITY STATE ZIP CODE	
NAME OF OTHER HEALTH AND/OR ACCIDENT INSURANCE COMPANY THROUGH MOTHER OR FEMALE GUARDIAN		POLICY NUMBER	
ADDRESS OF INSURANCE COMPANY		TELEPHONE NO. ()	
CITY		STATE ZIP CODE	
I understand that any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning facts material thereto commits a fraudulent act, which is a crime, and may subject such person to fines and/or imprisonment. I hereby authorize any school authority, trust fund, employer, insurance company or person who has attended or examined the claimant to disclose to Myers-Stevens & Toohey & Co., Inc., when requested to do so, any information regarding any injury, illness, policy coverage, medical history, consultation, prescription or treatment, and copies of all hospital or medical records and itemized bills, and to pay benefits based upon this information. A photostatic copy of this authorization shall be considered as valid and effective as the original.		PARENT OR GUARDIAN SIGNATURE X	
AUTHORIZATION TO PAY BENEFITS TO PROVIDER. I authorize payment of Medical payments to Physician or Supplier for Services on the attached.		RELATIONSHIP TO STUDENT DATE	
SIGNATURE OF PARENT OR GUARDIAN _____ DATE _____			

CLAIM FILING PROCEDURE

- ① Report school related injuries to the school within 72 hours.
- ② Have school complete PART A. (Parents may fill out PART A if injury is not school related.)
- ③ Parent or guardian complete PART B.
- ④ **IMPORTANT: Both parts must be completed in full or claim will not be processed.**
- ⑤ Mail form to our office with all itemized bills **within 90 days of the first date of treatment.**
- ⑥ At the same time, please file a claim with your other family health and/or accident carrier. This can include employee plans, union plans, CHAMPUS (military plans), service contracts, self-insured benefit plan, or health maintenance organizations (HMO's).
- ⑦ When you receive a notice of payment, a notice of denial, or a letter stating you have met your deductible from your other health and/or accident carrier, please forward this information to our office.
- ⑧ If you have any questions, please call our office at 949-348-0656.

COMMONLY ASKED QUESTIONS

Do I have to go to a specific doctor or hospital?

No, you can go to the doctor or hospital of your choice. However, if you go to a doctor or hospital that is part of the  Beech Street preferred provider network, you may have your out-of-pocket expenses significantly reduced. To find a participating doctor or hospital in your area, call 800-877-1666, 24-hours a day, 7-days a week or log on to www.beechstreet.com

Do I need to attach a claim form with all bills?

No, only one claim form is required per injury.

Do you offer family coverage?

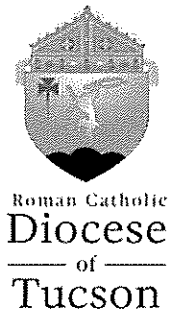
Yes. Please contact the office for information.



myers • stevens & toohey & co., inc.

26101 marguerite parkway
mission viejo, california 92692-3203
(949) 348-0656
fax (949) 348-2630

For residents of California: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.



School Health Services

CERTIFICATE OF CHRONIC HEALTH CONDITION For School Year 20__ - 20__

Student Name: _____ Birth Date: _____
School: _____ Grade: _____ Student #: _____
Number of school days absent this year: _____ as of this date: _____

I authorize the Diocese of Tucson Catholic Schools and my Health Care Provider to exchange information provided in this Certificate of Chronic Health Condition.

Parent Name

Parent Signature

Date

Health Care Provider – Please Review These Instructions Before Completing This Form

The purpose of this form is to enable a health care provider to certify that a Diocese of Tucson Catholic Schools student qualifies as a student with a chronic health condition. Certification is appropriate **only** if the student will be unable to attend school frequently or for substantial periods due to illness, disease, injury (accident), or pregnancy complications. Certification is not appropriate if the health condition is not sufficiently debilitating to prevent the student from attending school. By state law, this certification may be provided only by a licensed medical doctor, osteopathic physician, podiatrist, naturopathic physician, chiropractor, physician's assistant, or registered nurse practitioner.

HEALTH CARE PROVIDER – PLEASE COMPLETE THE FOLLOWING:

Student's diagnosed health condition: _____

Is the student's health condition active currently? ___no / ___yes Comment: _____

Is the student currently able to attend school? ___no / ___yes / ___yes with these accommodations: _____

Is the student currently able to participate in physical activity? ___no / ___yes / ___yes with these accommodations: _____

Do you expect the student to miss more than 9 school days per semester? ___no / ___yes

Comment: _____

If you are able, please indicate when the student's health condition is expected to end: _____

Health Care Provider Name Printed

Licensing Title

Health Care Provider Signature

Date

Phone: _____

Fax: _____

Business Name and Address: _____

DIABETES MANAGEMENT ASSESSMENT FORM

This form is designed to create a partnership among the school health team, the parent/guardian, and when appropriate the student, in safely and effectively managing diabetes in the school setting.

____ Set up meeting with student's parents, student, and teachers. Meeting date & time: _____

Basic Information

- 1) Student's Name _____ Age _____ DOB _____ Grade/Room _____
- 2) Parent's Names and contact #s:
- | | | | |
|--------------|--------------|--------------|--------------|
| Mother _____ | Home # _____ | Cell # _____ | Work # _____ |
| Father _____ | Home # _____ | Cell # _____ | Work # _____ |
- 3) Diagnosis: Type 1 Diabetes _____ Type 2 Diabetes _____
- 4) List insulin(s) or medication(s) _____
- 5) Date of diabetes diagnosis _____
- 6) Student's Pediatric Endocrinologist/Pediatrician and contact numbers:
- Name _____ Phone #s _____
- 7) Student's certified diabetes educator (CDE)/nurse _____ Phone # _____
- 8) Diabetic Medical Orders signed by physician (date) _____

Student's Diabetes Knowledge and Self-Management Skill Level

- 1) Blood glucose testing—who?
- ____ Student tests independently
- ____ Student tests with verification of number on glucometer by designated staff _____
- ____ Student needs assistance with testing and/or must be done by designated staff _____
- 2) Blood glucose testing—where?
- Health Office _____ Classroom _____ Other _____
- 3) Blood glucose testing—when?
- ____ Specify times _____
- ____ Exercise should be avoided or delayed if blood glucose lower than _____
- ____ Student's normal range _____
- 4) Disposal of blood testing materials (sharps, strips, wipes, etc.)
- ____ Plan and procedure (specify locations) _____
- ____ Student has demonstrated proper disposal methods, per above plan.
- ____ Designated staff to oversee proper disposal.
- 5) Insulin injection or pump bolus
- ____ Administers independently, using: Pump _____ Pen _____ Syringe _____
- ____ Student administers with verification of dose by designated staff _____
- ____ Student self-injects using: Syringe _____ Pen _____
- ____ OR with verification of designated staff _____
- ____ Administered by designated staff _____
- ____ Student boluses with verification of designated staff _____
- ____ Other _____
- 6) Snacks and meals
- ____ Student monitors independently
- ____ Daily snack @ (time) _____
- ____ Assistance needed from designated staff for daily snack in Health Office @ _____
- ____ Student will keep snacks on person or at their desk
- ____ Arrangements needed for classroom parties and food treats _____
- ____ Other _____
- 7) Treatment of **moderate** low blood sugar—(specify BG range for “moderate”): _____
- ____ List student's signs and symptoms here _____
- ____ Student recognizes low blood sugar and self-treats.
- 8) Special arrangements
- ____ Parents will provide backup supplies for pump (infusion sets, batteries, emergency insulin and syringes, other)
- ____ Student will insert new infusion set, if necessary
- ____ New infusion set inserted (if necessary) by designated staff _____
- ____ Parent will come to school to insert new infusion set if needed
- ____ Parent will provide an emergency backup lunch to be kept in health office
- ____ Other _____

DIABETES MEDICAL ORDERS

Student _____ D.O.B. _____ Grade _____ Room _____

BLOOD GLUCOSE TARGET RANGE: _____ mg/dl to _____ mg/dl

Blood Glucose Testing:

☐ independent

☐ needs assistance

_____ before AM snack

_____ before lunch

_____ before after-school sports

_____ when student feels low/high or ill

_____ other times _____

_____ if BG is less than _____ mg/dl or BG is greater than _____, call parent*.

Comments: _____

*For BG lower than _____ or over _____ see Recommendation for Treatment on reverse side.

Urine Ketones Testing:

_____ For BG greater than _____ mg/dl, do ketone testing*.

*If ketones are positive, contact parent and encourage sugar-free fluids.

Insulin Injection or Pump Bolus:

☐ independent

☐ needs assistance

Type of Insulin _____

_____ Always call parent for dose.

_____ Bolus for meal, based on carbohydrate count.

_____ Correction or supplemental bolus for high BG

Comments: _____

For Students with Insulin Pump:

Type of pump: _____

Does student need assistance with pump skills?

☐ Yes

☐ No

Comments: _____

Seizure, Unable to Swallow and/or Loss of Consciousness:

_____ Glucose gel and **call 911.**

_____ Glucose gel, 1 mg of Glucagon* IM or SQ and **call 911.**

*Glucagon to be administered by RN, paramedics, or parent only.

I give my permission for the school to contact the health care provider(s) regarding the treatment of my child's diabetes.

Physician Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Asthma Action Plan



Name _____ DOB ____/____/____

Severity Classification ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

Asthma Triggers (list) _____

Peak Flow Meter Personal Best _____

Green Zone: Doing Well

Symptoms: Breathing is good – No cough or wheeze – Can work and play – Sleeps well at night

Peak Flow Meter _____ (more than 80% of personal best)

Control Medicine(s)	Medicine	How much to take	When and how often to take it
	_____	_____	_____
	_____	_____	_____

Physical Activity ☐ Use albuterol/levalbuterol ____ puffs, 15 minutes before activity
☐ with all activity ☐ when you feel you need it

Yellow Zone: Caution

Symptoms: Some problems breathing – Cough, wheeze, or chest tight – Problems working or playing – Wake at night

Peak Flow Meter _____ to _____ (between 50% and 79% of personal best)

Quick-relief Medicine(s) ☐ Albuterol/levalbuterol ____ puffs, every 4 hours as needed

Control Medicine(s) ☐ Continue Green Zone medicines

☐ Add _____ ☐ Change to _____

You should feel better within 20–60 minutes of the quick-relief treatment. If you are getting worse or are in the Yellow Zone for more than 24 hours, THEN follow the instructions in the RED ZONE and call the doctor right away!

Red Zone: Get Help Now!

Symptoms: Lots of problems breathing – Cannot work or play – Getting worse instead of better – Medicine is not helping

Peak Flow Meter _____ (less than 50% of personal best)

Take Quick-relief Medicine NOW! ☐ Albuterol/levalbuterol ____ puffs, _____ (how frequently)

Call 911 immediately if the following danger signs are present

- Trouble walking/talking due to shortness of breath
- Lips or fingernails are blue
- Still in the red zone after 15 minutes

Emergency Contact Name _____ Phone (____) _____ - _____

Healthcare Provider Name _____ Phone (____) _____ - _____



FARE
Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergy to: _____

Weight: _____ lbs. Asthma: ☐ Yes (higher risk for a severe reaction) ☐ No

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following allergens: _____

THEREFORE:

- ☐ If checked, give epinephrine immediately if the allergen was **LIKELY** eaten, for **ANY** symptoms.
- ☐ If checked, give epinephrine immediately if the allergen was **DEFINITELY** eaten, even if no symptoms are apparent.

FOR ANY OF THE FOLLOWING: **SEVERE SYMPTOMS**



LUNG

Shortness of breath, wheezing, repetitive cough



HEART

Pale or bluish skin, faintness, weak pulse, dizziness



THROAT

Tight or hoarse throat, trouble breathing or swallowing



MOUTH

Significant swelling of the tongue or lips



SKIN

Many hives over body, widespread redness



GUT

Repetitive vomiting, severe diarrhea



OTHER

Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION
of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.
 - Consider giving additional medications following epinephrine:
 - » Antihistamine
 - » Inhaler (bronchodilator) if wheezing
 - Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
 - If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
 - Alert emergency contacts.
 - Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS



NOSE

Itchy or runny nose, sneezing



MOUTH

Itchy mouth



SKIN

A few hives, mild itch



GUT

Mild nausea or discomfort

FOR MILD SYMPTOMS FROM MORE THAN ONE SYSTEM AREA, GIVE EPINEPHRINE.

FOR MILD SYMPTOMS FROM A SINGLE SYSTEM AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

Epinephrine Dose: ☐ 0.01 mg IM ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

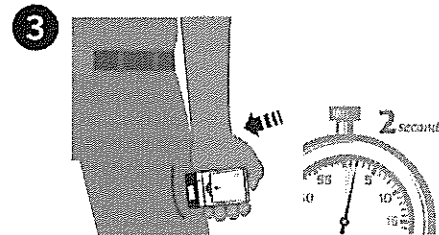


FARE
Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

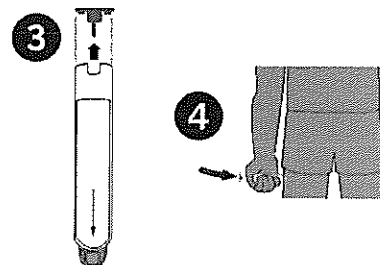
HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

1. Remove Auvi-Q from the outer case.
2. Pull off red safety guard.
3. Place black end of Auvi-Q against the middle of the outer thigh.
4. Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.
5. Call 911 and get emergency medical help right away.



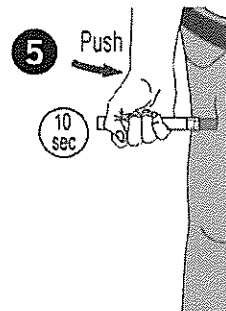
HOW TO USE EPIPEN® AND EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
5. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
6. Remove and massage the injection area for 10 seconds.
7. Call 911 and get emergency medical help right away.



HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENAClick®), USP AUTO-INJECTOR, IMPAX LABORATORIES

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip.
3. Grasp the auto-injector in your fist with the red tip pointing downward.
4. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh.
5. Press down hard and hold firmly against the thigh for approximately 10 seconds.
6. Remove and massage the area for 10 seconds.
7. Call 911 and get emergency medical help right away.



ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____
DOCTOR: _____ PHONE: _____
PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____
PHONE: _____
NAME/RELATIONSHIP: _____
PHONE: _____



FARE
Food Allergy Research & Education

PLAN DE ATENCIÓN DE EMERGENCIAS DE ALERGIAS ALIMENTARIAS Y ANAFILAXIA

Nombre _____ Fecha de nacimiento: _____

Alérgico a: _____

Peso: _____ kilos. Asma: ☐ Sí (Riesgo más alto de reacción grave) ☐ No

NOTA: No recurra a antihistamínicos ni inhaladores (broncodilatadores) para tratar una reacción grave. UTILICE EPINEFRINA.

Extremadamente reactivo a los siguientes alérgenos: _____

POR LO TANTO:

☐ Si esta opción está marcada y es PROBABLE que se ha ingerido el alérgeno, administre epinefrina de inmediato ante CUALQUIERA de estos síntomas.

☐ Si esta opción está marcada y es SEGURO que se ha ingerido el alérgeno, administre epinefrina de inmediato aunque no se observe ningún síntoma.

ANTE CUALQUIERA
DE LOS SIGUIENTES:

SÍNTOMAS GRAVES



PULMÓN

Falta de aire,
sibilancia,
muchos tos



CORAZÓN

Tez azulada o
pálida, desmayo,
pulso débil,
mareo



GARGANTA

Ronquera
u oclusión,
dificultad para
tragar o respirar



BOCA

Hinchazón
significativa de
la lengua o los
labios



PIEL

Urticaria
extendida en las
distintas partes
del cuerpo,
enrojecimiento
generalizado



INTESTINOS

Vómitos
reiterados,
diarrea grave



OTRO

Sensación de que
va a pasar algo
malo, ansiedad,
confusión.

**O UNA
COMBINACIÓN**
de los síntomas
de las distintas
áreas

1. INYECTE EPINEFRINA DE INMEDIATO

- Llame al 911. Avise al operador telefónico que el paciente tiene anafilaxia y puede necesitar epinefrina cuando llegue el equipo de emergencia.
- Considere la administración de otros medicamentos además de la epinefrina:
 - Antihistamínico
 - Inhalador (broncodilatador) en caso de respiración sibilante
- Mantenga al paciente en posición horizontal, con las piernas en alto y abrigado. Si tiene dificultades para respirar o vómitos, manténgalo sentado o tendido sobre un costado.
- Si los síntomas no mejoran o vuelven a aparecer, puede administrar otras dosis adicionales de epinefrina a partir de los 5 minutos de la administración de la última dosis.
- Comuníquese con los contactos de emergencia.
- Lleve al paciente a la sala de emergencias, aunque los síntomas hayan desaparecido. (El paciente debe permanecer en la guardia médica durante por lo menos 4 horas porque los síntomas pueden reaparecer).

SÍNTOMAS LEVES



NARIZ

Picazón o
moqueo nasal,
estornudos



BOCA

Picazón
bucal



PIEL

Algunas
ronchas,
picazón leve



INTESTINO

Náuseas leves o
malestar

**EN CASO DE SÍNTOMAS LEVES EN MÁS DE UN
ÁREA DEL CUERPO, ADMINISTRE EPINEFRINA.**

**EN CASO DE SÍNTOMAS LEVES EN UN ÁREA ÚNICA
SIGA ESTAS INSTRUCCIONES:**

- Se pueden administrar antihistamínicos, con prescripción médica.
- Quédese junto a la persona; comuníquese con los contactos de emergencia.
- Observe atentamente los posibles cambios. Si los síntomas empeoran, administre epinefrina.

MEDICAMENTOS/DOSIS

Marca de epinefrina o fármaco genérico: _____

Dosis de epinefrina: ☐ 0,01 mg IM ☐ 0,15 mg IM ☐ 0,3 mg IM

Marca de antihistamínico o fármaco genérico: _____

Dosis de antihistamínico: _____

Otros (por ejemplo, broncodilatador en caso de sibilancia): _____

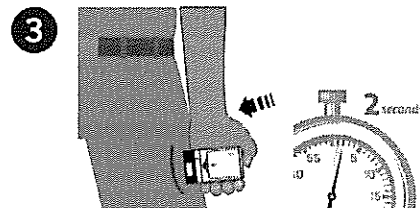


FARE
Food Allergy Research & Education

PLAN DE ATENCIÓN DE EMERGENCIAS DE ALERGIAS ALIMENTARIAS Y ANAFILAXIA

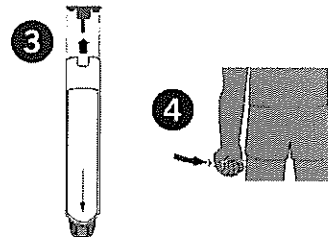
CÓMO UTILIZAR AUVI-Q® (INYECCIÓN DE EPINEFRINA, USP), KALEO

1. Retire AUVI-Q del estuche externo.
2. Saque la tapa de seguridad roja.
3. Coloque el extremo negro de AUVI-Q® contra la parte exterior media del muslo.
4. Oprima firmemente hasta escuchar un clic y un silbido, mantenga presionado por 2 segundos.
5. Llame al 911 y pida asistencia médica de emergencia de inmediato.



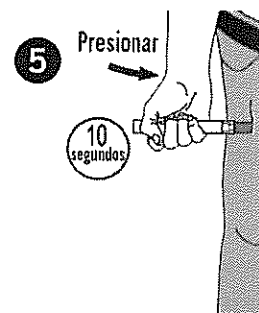
CÓMO USAR EL AUTOINYECTOR DE EPINEFRINA EPIPEN® Y EPIPEN JR® Y LA INYECCIÓN DE EPINEFRINA (FÁRMACO GENÉRICO AUTORIZADO DE EPIPEN®), USP (AUTOINYECTOR), MYLAN

1. Retire el autoinyector EpiPen® o EpiPen Jr® del tubo transparente.
2. Sujete el autoinyector firmemente con el puño con la punta naranja (el extremo de la aguja) apuntando hacia abajo.
3. Con la otra mano, retire el protector de seguridad azul tirando firmemente hacia arriba.
4. Gire y oprima con firmeza el autoinyector contra la parte exterior media del muslo hasta que haga clic.
5. Sostenga firmemente en el lugar durante 3 segundos (cuenta lentamente 1, 2, 3).
6. Retire el dispositivo y masajee el área durante 10 segundos.
7. Llame al 911 y pida asistencia médica de emergencia de inmediato.



CÓMO UTILIZAR LA INYECCIÓN DE EPINEFRINA IMPAX (GENÉRICO AUTORIZADO DE ADRENALICK®), USP, AUTOINYECTOR, LABORATORIOS IMPAX

1. Retire del autoinyector de epinefrina de su estuche protector.
2. Saque las dos tapas de extremo azul. Ahora podrá ver una punta roja.
3. Sujete el autoinyector firmemente con el puño con la punta roja apuntando hacia abajo.
4. Coloque la punta roja contra la parte exterior media del muslo en un ángulo de 90°, en posición perpendicular al muslo.
5. Oprima y sostenga con firmeza durante aproximadamente 10 segundos.
6. Retire el dispositivo y masajee el área durante 10 segundos.
7. Llame al 911 y pida asistencia médica de emergencia de inmediato.



INFORMACIÓN DE ADMINISTRACIÓN Y SEGURIDAD PARA TODOS LOS AUTOINYECTORES:

1. No coloque el dedo pulgar, los demás dedos o la mano sobre la punta del autoinyector ni aplique la inyección fuera de la parte exterior media del muslo. En caso de inyección accidental, diríjase inmediatamente a la sala de emergencias más cercana.
2. Si administra el medicamento a un niño pequeño, sostenga su pierna firmemente antes y durante la aplicación para evitar posibles lesiones.
3. Si es necesario, la epinefrina se puede aplicar a través de la ropa.
4. Llame al 911 inmediatamente luego de aplicar la inyección.

INSTRUCCIONES/INFORMACIÓN ADICIONAL (la persona puede llevar epinefrina, el paciente puede autoadministrarse la medicación, etc.):

Trate a la persona antes de llamar a los contactos de emergencia. Las primeras señales de una reacción pueden ser leves, pero los síntomas pueden agravarse con rapidez.

CONTACTOS DE EMERGENCIA – LLAME AL 911

EQUIPO DE RESCATE: _____

MÉDICO: _____ TELÉFONO: _____

PADRE O TUTOR: _____ TELÉFONO: _____

OTROS CONTACTOS DE EMERGENCIA

NOMBRE/RELACIÓN: _____

TELÉFONO: _____

NOMBRE/RELACIÓN: _____

TELÉFONO: _____

Seizure Action Plan

Effective Date _____

This student is being treated for a seizure disorder. The information below should assist you if a seizure occurs during school hours.

Student's Name _____	Date of Birth _____
Parent/Guardian _____	Phone _____ Cell _____
Other Emergency Contact _____	Phone _____ Cell _____
Treating Physician _____	Phone _____
Significant Medical History _____	

Seizure Information

Seizure Type	Length	Frequency	Description

Seizure triggers or warning signs: _____

Student's response after a seizure: _____

Basic First Aid: Care & Comfort

Please describe basic first aid procedures: _____

Does student need to leave the classroom after a seizure? ☐ Yes ☐ No

If YES, describe process for returning student to classroom: _____

Basic Seizure First Aid

- Stay calm & track time
- Keep child safe
- Do not restrain
- Do not put anything in mouth
- Stay with child until fully conscious
- Record seizure in log

For tonic-clonic seizure:

- Protect head
- Keep airway open/watch breathing
- Turn child on side

Emergency Response

A "seizure emergency" for this student is defined as: _____

Seizure Emergency Protocol

(Check all that apply and clarify below)

- ☐ Contact school nurse at _____
- ☐ Call 911 for transport to _____
- ☐ Notify parent or emergency contact
- ☐ Administer emergency medications as indicated below
- ☐ Notify doctor
- ☐ Other _____

A seizure is generally considered an emergency when:

- Convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- Student has repeated seizures without regaining consciousness
- Student is injured or has diabetes
- Student has a first-time seizure
- Student has breathing difficulties
- Student has a seizure in water

Treatment Protocol During School Hours (include daily and emergency medications)

Emerg. Med. ✓	Medication	Dosage & Time of Day Given	Common Side Effects & Special Instructions

Does student have a Vagus Nerve Stimulator? ☐ Yes ☐ No If YES, describe magnet use: _____

Special Considerations and Precautions (regarding school activities, sports, trips, etc.)

Describe any special considerations or precautions: _____

Physician Signature _____ Date _____

Parent/Guardian Signature _____ Date _____



Administrative Code R9-6-202.

Age of Birth	Race (c)
	<input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian

outcome _____
 S/Survived _____
 D/died, date: _____
 Regnant _____
 No _____
 Unknown _____
 Yes _____
 Est. due date: _____

	Lab	
swab		
swab	Lab	
	Lab	
swab		
swab	Lab	
	Lab	
swab		
swab	Lab	

Reporting Facility _____ Zip _____

**Apache (866) 804-8449;
Maricopa non-STDs (602) 375-7620;
Santa Cruz (520) 375-7620**

I hereby request and give my consent for the school nurse or person designated by the administrator to see that my child is given the medication indicated below. The medication will be furnished by me in the original container, labeled with the child's name; has a written order or prescription label from my medical provider; and is to be given as follows:

Student's Name _____ DOB _____ School _____ Hm Rm Teacher _____
 Doctor _____ Phone # _____ Fax # _____ Diagnosis _____
 Special Instructions _____ Side Effects _____ Month/Year _____

Date _____

Signature/Initials: _____ Signature/Initials: _____

[illegible]

**DIOCESE OF TUCSON SCHOOLS
STUDENT MEDICATION CONSENT / LOG**

Date →																			
AM																			
Initials																			
PM																			
Initials																			
Date →																			
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NOTES

DATE	TIME		DATE	TIME	

DOCUMENTATION OF RECEIPT OF MEDICATIONS

DATE RECEIVED	MEDICATION (Name and dosage)	Number of Tablets Amount of Liquid	LOT NUMBER	EXPIRATION DATE	RECEIVED BY (SIGNATURE)



School Health Services

Over-the-Counter Medication Authorization Form

Student Name: _____	Birth date: _____	Grade: _____
Medication allergies: _____	Child's weight: _____	

NON-PRESCRIPTION MEDICATIONS

Health Office keeps the following medications in stock. All other non-prescription medications must be brought to Health Office by a parent/guardian in a manufacturer-labeled container. Students cannot carry their own medication. This medication authorization form is only valid for the 2017-18 school year. Please authorize medication administration by checking appropriate boxes or filling in other medication.

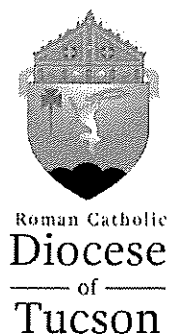
- | | | |
|---|---|--|
| <input type="checkbox"/> Children's acetaminophen | <input type="checkbox"/> Chloraseptic spray/mouthwash | <input type="checkbox"/> Calamine lotion |
| <input type="checkbox"/> Adult acetaminophen | <input type="checkbox"/> Cough drops | <input type="checkbox"/> Children's Benadryl |
| <input type="checkbox"/> Children's ibuprofen | <input type="checkbox"/> Tums/Mylanta | <input type="checkbox"/> Adult Benadryl |
| <input type="checkbox"/> Adult ibuprofen | <input type="checkbox"/> Antibiotic ointment | <input type="checkbox"/> Heating packs/pad and ice packs |
| <input type="checkbox"/> Sterile normal saline eye drops/wash | <input type="checkbox"/> Bactine | <input type="checkbox"/> Vaseline |

For above medications, the medication manufacturer's recommendations will be followed for dosage and frequency based on student age, height and weight, unless otherwise directed by student's physician. If so, please have physician/prescriber fill out the following:

Medication _____ Dose _____ Frequency _____
Reason _____

Physician/Prescriber signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____



School Health Services

Dear Parents/Guardians,

The Diocese of Tucson Department of Catholic Schools has implemented a new policy regarding the use of two emergency medications: **auto-injectable epinephrine and albuterol inhalers**.

Participating schools will now have these two medications stocked and available for use in the case of an emergency. These medications will be kept in the health office of each participating school and administered by trained staff. The primary use of these medications is to aid a student, (previously undiagnosed with a severe allergy or asthma), experiencing a life-threatening event, such as anaphylaxis or an asthma attack.

Auto-injectable epinephrine is used to treat anaphylaxis, a potentially dangerous allergic reaction. In the most extreme case, the airway is blocked because of swelling around the voice box and because of a spasm of the windpipe and air passages of the lung. There may also be rapid and dramatic drops in blood pressure leading to the loss of consciousness and/or shock. It can be triggered by an allergy to a particular food, biting or stinging insects, medications, latex or a variety of other allergic triggers.

Albuterol inhalers are used to treat an asthma attack, which can include one or all of the following symptoms: Difficulty breathing, coughing, wheezing, tightness in chest, shortness of breath, chest pain, and blueness around the lips or fingernails.

Please be aware that the parents and guardians of a student with a diagnosed severe allergy and/or asthma are still required to provide the school with medications specifically prescribed to that student. The implementation of this policy to stock these potentially life-saving medications, is not to replace the responsibility of the parent/guardian to provide the school with the student's allergy and/or asthma medication.

Also, please note that these medications are only available to students enrolled in kindergarten through twelfth grade during regular school hours and school-sponsored activities. State-licensed preschools and before and after-care programs are to follow the protocol as mandated by the Arizona Department of Health Services Bureau of Child Care Licensing. Under this State protocol, preschools and before and after-care programs are only allowed to administer medications that are prescribed to an individual student and, therefore, administration of stock medications is not permitted.

Finally, parents and guardians must fill out the "Parent's Consent Form for Giving Albuterol in an Emergency" and "Parent's Consent Form for Giving Epinephrine in an Emergency" provided by the student's school.

If you have any further questions or concerns please contact your school's health office or feel free to contact me, the Diocese of Tucson Catholic Schools Health Coordinator at (520) 325-2431 ext. 109 or mjoyce@ssppucson.org.

In Christ,

Megan Joyce



Servicios de Salud Escolar

Estimados padres / tutores:

El Departamento de Escuelas Católicas de la Diócesis de Tucson ha implementado una nueva política con relación al uso de dos medicamentos de emergencia: **la epinefrina autoinyectable y los inhaladores de albuterol**.

A partir de ahora, las escuelas participantes almacenarán estos dos medicamentos y los tendrán listos para usarse en caso de una emergencia. Dichos medicamentos se guardarán en la oficina de salud de cada escuela participante y serán administrados por personal capacitado. El uso principal de estos medicamentos es brindar auxilio a aquel estudiante, (a quien previamente se le haya diagnosticado alergia severa o asma), y que está enfrentando un suceso que amenaza su vida, como la anafilaxis o un ataque asmático.

La epinefrina autoinyectable sirve para tratar la anafilaxis, reacción alérgica potencialmente peligrosa. En el caso más extremo, las vías respiratorias se bloquean debido a que la laringe se inflama y se produce un espasmo en la tráquea y los conductos respiratorios del pulmón. Es posible que también ocurra una caída rápida y dramática en la presión sanguínea lo que conlleva a la pérdida del conocimiento y/o a sufrir un *shock*. El factor desencadenante puede ser una alergia a una comida en particular, la picadura o mordedura de un insecto, medicamentos, el látex o una combinación de varios factores alérgicos desencadenantes.

Los inhaladores de albuterol se utilizan para tratar un ataque asmático, en el que se puede presentar uno o todos los síntomas siguientes: dificultad para respirar, tos, sibilancias, opresión en el pecho, falta de aliento, dolor en el pecho y color azulado alrededor de los labios o las uñas.

Suplicamos a los padres y tutores del estudiante, a quien se le ha diagnosticado alergia severa y/o asma, estar conscientes de que se les sigue requiriendo proveer a la escuela aquellos medicamentos que específicamente le han sido recetados al estudiante. La implementación de esta política, la de almacenar medicamentos que potencialmente tienen la capacidad de salvar la vida, no reemplaza la responsabilidad del padre / madre / tutor para entregarle a la escuela los medicamentos que sirven para tratar la alergia y/o asma del estudiante.

También, les suplicamos tomar nota de que dichos medicamentos solo están disponibles para aquellos estudiantes que se encuentren matriculados, desde el jardín de niños hasta el doceavo grado, durante el horario escolar normal y durante las actividades patrocinadas por la escuela.

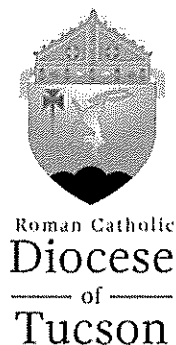
Las escuelas de educación preescolar acreditadas por el Estado y los programas que ofrecen servicios de cuidado infantil, antes y después del horario escolar, deberán seguir el protocolo, tal como lo ordena la *Agencia para la Acreditación de Centros de Cuidado Infantil del Departamento de Salud de Arizona (Department of Health Services - Bureau of Child Care Licensing)*. Bajo este protocolo estatal, a las escuelas de educación preescolar y a los programas de cuidado infantil que brindan servicios, antes y después del horario escolar, únicamente se les permite administrar medicamentos que le han sido recetados a un determinado estudiante y, por lo tanto, no se les permite administrar medicamentos que tengan en sus existencias.

Finalmente, los padres y tutores deberán llenar el "*Formulario de consentimiento de los padres para la administración de albuterol en caso de emergencia*"; y el "*Formulario de consentimiento de los padres para la administración de epinefrina en caso de emergencia*", que les ha sido proporcionada por la escuela del estudiante.

Si tienen alguna pregunta o duda adicional, favor de ponerse en contacto con la oficina de salud de su escuela o siéntanse en la libertad de ponerse en contacto conmigo, Coordinadora en Salud de las Escuelas Católicas de la Diócesis de Tucson al (520) 325-2431 ext. 109 o al correo electrónico mjoyce@ssppucson.org.

En el amor de Cristo,

Megan Joyce



Name of School
School Health Services
Emergency Medication
(Epinephrine Administration)

Procedure for Giving of Epinephrine in an Emergency

**The administration of Epinephrine for symptomatic children
who do not have prescribed Epinephrine.**

Anaphylaxis: A life-threatening allergic reaction. In the most extreme case, the airway is blocked because of swelling around the voice box and because of a spasm of the windpipe and air passages of the lung. There may also be rapid and dramatic drops in blood pressure (circulatory collapse) leading to the loss of consciousness and/or shock. The faster the beginning of symptoms, the more severe the reaction. Symptoms of anaphylaxis vary, but those involving the skin (hives, itching, skin redness) are most common. A majority of cases also involve swelling of the lips and tongue as well as of the airways (tightness in the throat, shortness of breath). Anaphylaxis may also involve the gastrointestinal system (nausea, stomach pain, vomiting, diarrhea, coughing), the cardiovascular system (fast heartbeat, chest pain, low blood pressure) or the central nervous system (headache, confusion). This reaction can be potentially triggered by:

- Insect venom: honeybee, wasp, hornet, yellow jacket; ants, deer flies, black flies, kissing bugs, etc.
- Drugs: penicillin and other antibiotics; local anesthetics like lidocaine, Novocain; pain medications such as aspirin; hormones such as insulin.
- Foods: egg white, milk, shellfish and other seafood, nuts and peanuts.
- Inhalants: pollens and strong odors, glue, typewriter whiteout, gasoline, etc.

Epinephrine: The drug in EpiPen® and EpiPen Jr® Auto-Injector is epinephrine. It constricts blood vessels to increase blood pressure, relaxes smooth muscles in the lungs to reduce wheezing and improve breathing, stimulates the heart (increases heart rate) and works to reduce hives and swelling that may occur around the face and lips.

A student presenting in anaphylaxis with respiratory distress, e.g., cyanosis, wheezing, poor air movement, shock, respiratory failure, needs immediate emergency care. If there is no action plan or prescribed auto-injector and/or this is a previously undiagnosed student, then the following protocol will be followed by trained staff:

1. Get a quick history if possible
 - a. Check for medical alert tag
 - b. When did it happen
 - c. What was eaten, inhaled or touched
 - d. Has it happened before
2. Assess for shortness, wheezing, harsh sounds during breathing, hives, swelling of lips, tongue and throat, confusion, unresponsiveness, lack of bladder control, very rapid low pulse, and low blood pressure.
3. Get someone to call 911 **immediately**, and then call the school nurse.
4. Institute basic life support consisting of ABC's of maintenance of airway, breathing, circulation (CPR) if needed.
5. Give "epi-pen" (or epinephrine/adrenaline) as ordered. Massage area well. Repeat one time in 15 minutes if necessary.
6. If the offending agent can be identified and is still present, be sure to remove it from the area or move the person away from it.

COMMON SIDE EFFECTS: Be sure to also tell the school health personnel all the medicines you take, especially medicines for asthma. Common side effects include fast, irregular or "pounding" heartbeat, sweating, nausea or vomiting, breathing problems, paleness, dizziness, weakness, shakiness, headache, feelings of over excitement, nervousness or anxiety. These side effects usually go away quickly if you lie down and rest.



****Name of School****
School Health Services
Emergency Medication Consent Form
(Epinephrine Administration)

Parent's consent form for giving Epinephrine in an emergency

Name of Child _____

Parent/ Guardian's Name _____ **Relationship** _____

Best Contact Number _____

**This consent is for the administration of Epinephrine for symptomatic children
who do not have prescribed Epinephrine.**

Anaphylaxis: A life-threatening allergic reaction. In the most extreme case, the airway is blocked because of swelling around the voice box and because of a spasm of the windpipe and air passages of the lung. There may also be rapid and dramatic drops in blood pressure (circulatory collapse) leading to the loss of consciousness and/or shock. The faster the beginning of symptoms, the more severe the reaction. Symptoms of anaphylaxis vary, but those involving the skin (hives, itching, skin redness) are most common. A majority of cases also involve swelling of the lips and tongue as well as of the airways (tightness in the throat, shortness of breath). Anaphylaxis may also involve the gastrointestinal system (nausea, stomach pain, vomiting, diarrhea, coughing), the cardiovascular system (fast heartbeat, chest pain, low blood pressure) or the central nervous system (headache, confusion). This reaction can be potentially triggered by:

- Insect venom: honeybee, wasp, hornet, yellow jacket; ants, deer flies, black flies, kissing bugs, etc.
- Drugs: penicillin and other antibiotics; local anesthetics like lidocaine, Novocain; pain medications such as aspirin; hormones such as insulin.
- Foods: egg white, milk, shellfish and other seafood, nuts and peanuts.
- Inhalants: pollens and strong odors, glue, typewriter whiteout, gasoline, etc.

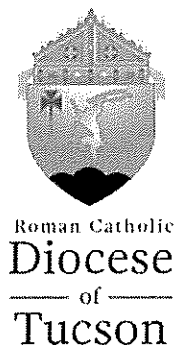
- ☐ **I give my consent to administer Epinephrine**
- ☐ **I do not give my consent to administer Epinephrine**
- ☐ **My child already has a consent form on file and Epinephrine at school.**

Parent/ Guardian Signature

Date

Teacher

Grade/ Room #



****Nombre de la Escuela****

Servicios de salud escolar

Medicación de emergencia

(Administración de epinefrina)

Procedimiento para la administración de *epinefrina* en caso de emergencia

Administración de epinefrina a niños sintomáticos a quienes no se les ha recetado epinefrina.

Anafilaxis: Reacción alérgica potencialmente mortal. En el caso más extremo, las vías respiratorias se bloquean debido a que la laringe se inflama y se produce un espasmo en la tráquea y en las vías respiratorias del pulmón. Es posible que también ocurra una caída rápida y dramática en la presión sanguínea (colapso circulatorio) que conduzca a la pérdida del conocimiento y / o a sufrir un shock. Cuanto más rápido se desencadenen los síntomas, más grave será la reacción. Los síntomas de la anafilaxia varían, pero los más comunes son aquellos que afectan la piel (la urticaria, la comezón, el enrojecimiento de la piel). En la mayoría de los casos también se observa una inflamación de los labios y la lengua, así como de las vías respiratorias (opresión en la garganta, dificultad para respirar). La anafilaxia también puede afectar al sistema gastrointestinal (náuseas, dolor de estómago, vómitos, diarrea, tos); al sistema cardiovascular (aceleración del ritmo cardíaco, dolor torácico, presión arterial baja); o al sistema nervioso central (cefalea, confusión). Es posible que esta reacción sea causada por:

- El veneno de un insecto: abeja, avispa, avispon, avispa amarilla; hormigas, mosca de venado, mosca negra, etc.
- Medicamentos: penicilina y otros antibióticos; anestésicos locales como la lidocaína, la novocaína; analgésicos como la aspirina; hormonas como la insulina.
- Alimentos: clara de huevo, leche, pescado y otros mariscos, nueces y cacahuetes.
- Inhalantes: polen y olores fuertes, pegamento, corrector blanco de máquina de escribir, gasolina, etc.

Epinefrina: El fármaco que se encuentra en el *EpiPen®* y el *EpiPen Jr® Auto Inyector* es la epinefrina. Contrae los vasos sanguíneos lo que permite incrementar la presión arterial; relaja los músculos lisos de los pulmones lo que permite reducir las sibilancias y mejorar la respiración; estimula el corazón (aumenta la frecuencia cardíaca) y trabaja para reducir la urticaria y la hinchazón que puede aparecer en la cara y alrededor de los labios.

En el caso de que un estudiante se presente con anafilaxia, dificultad para respirar, cianosis, sibilancias, flujo deficiente de aire, en shock, o falla respiratoria, necesita recibir inmediatamente atención de emergencia. En caso de no haber un plan de acción o receta médica para un autoinyector y / o se trate de un estudiante que no haya sido previamente diagnosticado, el personal capacitado deberá seguir el siguiente protocolo:

1. De ser posible, crear rápidamente un historial
 - a. Revisar la etiqueta de alerta médica
 - b. Ver cuando sucedió
 - c. Ver qué ha comido, inhalado o tocado
 - d. Ver si ha sucedido anteriormente
2. Evaluar si la respiración es corta, si hay sibilancias, sonidos agudos durante la respiración, urticaria, hinchazón de los labios, lengua y garganta, confusión, falta de respuesta, falta de control de la vejiga, pulso muy rápido y presión arterial baja.
3. Pedirle a alguien que llame al 911 de inmediato, y luego llamar a la enfermera de la escuela.
4. Instituir el soporte básico de vida, consistente con el ABC de mantenimiento de las vías respiratorias, respiración, circulación, (RCP / respiración cardiopulmonar) en caso de ser necesario.
5. Administrar el "EpiPen" (epinefrina / adrenalina) según lo indicado. Masajear bien la zona. De ser necesario, volver a administrar después de 15 minutos.
6. Si se puede identificar el agente causante y todavía está presente, asegurarse de retirarlo de la zona o alejar a la persona de éste.

EFFECTOS SECUNDARIOS COMUNES: Asegúrese de informar al personal de salud de la escuela sobre todos los medicamentos que toma, especialmente los medicamentos para el asma. Entre los efectos secundarios comunes se incluyen: latidos cardíacos acelerados, irregulares o "fuertes", sudoración, náuseas o vómitos, problemas respiratorios, palidez, mareos, debilidad, temblores, dolor de cabeza, agitación, nerviosismo o ansiedad. Estos efectos secundarios suelen desaparecer rápidamente si se acuesta y descansa.



Nombre de la Escuela
Servicios de Salud Escolares
Formulario de consentimiento para
medicamentos de emergencia
(Administración de la Epinefrina)

**Formulario de consentimiento de los padres para la administración
de *epinefrina* en caso de una emergencia**

Nombre del niño(a) _____

Nombre del padre/ madre / tutor(a) _____ **Relación** _____

Mejor número de contacto _____

**Este consentimiento es para administrar epinefrina a niños sintomáticos a quienes
no se les ha recetado epinefrina.**

Anafilaxis. Reacción alérgica potencialmente mortal. En el caso más extremo, las vías respiratorias se bloquean debido a que la laringe se inflama y se produce un espasmo en la tráquea y en las vías respiratorias del pulmón. Es posible que también ocurra una caída rápida y dramática en la presión sanguínea (colapso circulatorio) que conduzca a la pérdida del conocimiento y / o a sufrir un shock. Cuanto más rápido se desencadenen los síntomas, más grave será la reacción. Los síntomas de la anafilaxia varían, pero los más comunes son aquellos que afectan la piel (la urticaria, la comezón, el enrojecimiento de la piel). En la mayoría de los casos también se observa una inflamación de los labios y la lengua, así como de las vías respiratorias (opresión en la garganta, dificultad para respirar). La anafilaxia también puede afectar al sistema gastrointestinal (náuseas, dolor de estómago, vómitos, diarrea, tos); al sistema cardiovascular (aceleración del ritmo cardíaco, dolor torácico, presión arterial baja); o al sistema nervioso central (cefalea, confusión). Es posible que esta reacción sea causada por:

- El veneno de un insecto: abeja, avispa, avispon, avispa amarilla; hormigas, mosca de venado, mosca negra, etc.
- Medicamentos: penicilina y otros antibióticos; anestésicos locales como la lidocaína, la novocaína; analgésicos como la aspirina; hormonas como la insulina.
- Alimentos: clara de huevo, leche, pescado y otros mariscos, nueces y cacahuets.
- Inhalantes: polen y olores fuertes, pegamento, corrector blanco de máquina de escribir, gasolina, etc.

- ☐ **Doy mi consentimiento para que se le administre la Epinefrina.**
☐ **No doy mi consentimiento para que se le administre la Epinefrina.**
☐ **Mi hijo ya tiene un formulario de consentimiento en el expediente para que se le administre la epinefrina y epinefrina en la escuela.**

Firma del Padre / Madre / Tutor/a

Fecha

Profesor/a

Grado escolar



Arizona Department of Health Services Bureau of EMS and Trauma Services

School Emergency Administration of Auto-Injectable Epinephrine Report Arizona Administrative Code R7-2-809

School Providing Injection

School Name here: ►			
Address here: ►			
City here: ►	District here: ►	Zip: here: ►	
Main Telephone Number here: ►	Fax Number here: ►		

Individual Injected

Name here: ►			
Age here: ►			
Legal Guardian Contact			
Name here: ►	Relationship here: ►		
Direct Telephone Number here: ►	E-mail Address here: ►		

Individual Administering Injection

Name: here ►	Position/Title here: ►	
Direct Telephone Number: here ►	E-mail Address: here ►	

Drug Administration

Date: here ►	Time: here ►	Number of Doses: here ►	
Reasons for drug administration here: ►			
Describe any problems with the drug administration here: ►			

Standing Order Authority

Physician Name here: ►			
Address here: ►			
City here: ►	AZ Medical License Number here : ►		
Main Telephone Number here: ►	Fax Number here: ►		

EMS Response

Time 911 was called: here ►	Time EMS Arrived: here ►	
Name of Transporting EMS Agency here: ►		
Name of Hospital Individual was Transported here: ►		

Comments:

Please provide any questions or concerns here: ►	
--	--

After completion, please forward this form to:

Noreen Adlin, NREMT-P
Trauma and EMS Operations Manager
Arizona Department of Health Services- Bureau of EMS and Trauma Services
Email: Noreen.adlin@azdhs.gov
Office Phone (602)364-3275 FAX Number: (602)364-3568
Mail: 150 North 18th Ave, Ste. 540, Phoenix, Arizona, 85007-3248



Name of School
School Health Services
Emergency Medication
(Albuterol Administration)

Procedure for Giving Albuterol in an Emergency

**The administration of albuterol in case of asthma exacerbation (or respiratory distress)
for symptomatic children who do not have prescribed albuterol.**

Possible Symptoms:

(May include one or more of the following)

- Coughing, wheezing, noisy breathing or decreased breath sounds, or whistling in the chest
- Difficult breathing, tightness in chest, shortness of breath, or chest pain
- Complaints of discomfort when breathing
- Shallow breathing, breathing hard and fast
- Nasal flaring (front part of nose opens wide to get in more air)
- Can only speak in short sentences or not able to speak
- Blueness around the lips or fingernails
- Chest retractions, use of accessory muscles
- Fast pulse

Intervention:

Severe Respiratory Distress: Quickly evaluate the child. **Call 911** and immediately administer albuterol 6 puffs 15-30 seconds apart. (For example: unable to speak, lips blue, decreased consciousness, tachycardia, shallow breaths, hypotension, retractions). Restrict physical activity and allow student to rest. Encourage student to breathe slowly and relax. Place the student in an area where he/she can be closely observed.

No response: Repeat 6 puffs of albuterol, each 15-30 seconds apart.

Respiratory Distress: Administer albuterol medication, 2-4 puffs from school stock supply for observable symptoms.

1. Contact parents (even if situation does not appear severe).
2. Reassess student after 10-15 minutes. Check for ease of breathing. If no improvement, then administer another 2-4 puffs of albuterol.
3. **If student is still not improving, contact 911.**
4. If student is improving, keep the student in the health office under supervision until breathing returns to normal.
5. Document on encounter card: Time, administration, respirations, pulse, and other noted symptoms followed by outcome.
6. Record data in statistical program and in student health record.
7. School Health Personnel to follow-up with student's family/physician.

Common side effects include nervousness, shaking (tremor), headache, dizziness, mouth/throat dryness or irritation, sore throat, cough, nausea, vomiting, dizziness, sleep problems (insomnia), hoarseness, runny or stuffy nose, muscle pain, or diarrhea.



****Name of School****
School Health Services
Emergency Medication Consent Form
(Albuterol Administration)

Parent's Consent Form for Giving Albuterol in an Emergency

Name of Child _____

Parent/ Guardian's Name _____ **Relationship** _____

Best Contact Number _____

This consent is for the administration of albuterol in the case of an asthma exacerbation (or respiratory distress) for symptomatic children who do not have a prescription for albuterol.

Possible Symptoms:

Albuterol may be given for Asthma Exacerbation which includes one or more of the following:

- Coughing, wheezing, noisy breathing or decreased breath sounds, or whistling in the chest
- Difficult breathing, tightness in chest, shortness of breath, or chest pain
- Complaints of discomfort when breathing
- Shallow breathing, breathing hard and fast
- Nasal flaring (front part of nose opens wide to get in more air)
- Can only speak in short sentences or not able to speak
- Blueness around the lips or fingernails
- Chest retractions, use of accessory muscles
- Fast pulse

It will be given as set out in the attached School Health Services Policy Procedure for Giving Albuterol in an Emergency

There are complications involved with this treatment including nervousness, shaking (tremor), headache, dizziness, mouth/throat dryness or irritation, sore throat, cough, nausea, vomiting, dizziness, sleep problems (insomnia), hoarseness, runny or stuffy nose, muscle pain, or diarrhea.

- ☐ **I give my consent to administer Albuterol**
- ☐ **I do not give my consent to administer Albuterol**
- ☐ **My child already has a consent form on file and Albuterol at school.**

Parent/ Guardian Signature

Date

Teacher

Grade/ Room #



*** Nombre de la Escuela ***
Servicios de Salud Escolares
Medicamento en caso de emergencia
(Administración de Albuterol)

Procedimiento para administrar Albuterol en caso de emergencia

Administración de albuterol en caso de exacerbación asmática (o dificultad respiratoria) para niños sintomáticos a quienes no se les ha recetado albuterol.

Posibles síntomas:

(Pueden presentarse uno o más de los siguientes)

- tos, sibilancias, respiración ruidosa o disminución de los ruidos respiratorios, o silbido en el pecho
- dificultad para respirar, opresión en el pecho, falta de aliento o dolor en el pecho
- molestias al respirar
- respiración superficial, respiración fuerte y rápida
- aleteo nasal (las fosas nasales se abren más para aspirar más aire)
- sólo puede hablar en frases cortas o no es capaz de hablar
- color azulado alrededor de los labios o las uñas
- retracciones del tórax, uso de músculos accesorios
- pulso rápido

Intervención:

Dificultad respiratoria grave: evalúe rápidamente al estudiante. Llame al 911 e inmediatamente administre 6 inhalaciones de albuterol, con pausas de 15 a 30 segundos, (Por ejemplo: si no puede hablar, si presenta labios azules, disminución del estado de conciencia, taquicardia, respiración superficial, hipotensión, retracciones del tórax). Restrinja la actividad física y permita al estudiante descansar. Pida al estudiante que respire lentamente y se relaje. Coloque al estudiante en un área en la cual pueda ser monitoreado/a.

Si no responde: Repita 6 inhalaciones de albuterol, con pausas de 15 a 30 segundos.

Dificultad respiratoria: Administre albuterol, de 2 a 4 inhalaciones del suministro de la escuela para observar los síntomas.

1. Póngase en contacto con los padres (incluso si la situación no parece grave).
2. Vuelva a evaluar al estudiante después de 10 ó 15 minutos. Cheque si se facilita respirar. Si no hay mejoría, administre otras 2 a 4 inhalaciones de albuterol.
3. **Si el estudiante no mejora, contacte al 911.**
4. Si el estudiante está mejorando, manténgalo bajo observación, en la enfermería, hasta que la respiración vuelva a la normalidad.
5. Documente la administración del medicamento: la hora, la respiración, pulso y otros síntomas descritos, seguidos por el resultado. Encounter card
6. Registre los datos en el programa estadístico y en el expediente de salud del estudiante.
7. El personal de salud escolar debe dar seguimiento con la familia/médico del alumno.

Entre los efectos secundarios comunes se incluyen: nerviosismo, agitación (temblores), dolor de cabeza, mareos, sequedad o irritación de boca y garganta, dolor de garganta, tos, náuseas, vómito, problemas para dormir (insomnio), ronquera, secreción o congestión nasal, dolor muscular, o diarrea.



Nombre de la Escuela
Servicios de Salud Escolares
Formulario de consentimiento para
medicamento en caso de emergencia
(administración de albuterol)

Formulario de consentimiento de los padres para la administración
de Albuterol en caso de emergencia

Nombre del estudiante _____

Nombre del Padre/Madre o tutor _____ **Relación** _____

Número de Teléfono _____

Este consentimiento sirve para autorizar la administración del albuterol, en caso de una exacerbación asmática (o dificultad respiratoria), para niños sintomáticos que no tienen una receta médica para el albuterol.

Posibles síntomas:

El albuterol se puede administrar en caso de exacerbación asmática cuando se presenta uno o más de los siguientes síntomas:

- tos, sibilancias, respiración ruidosa o disminución de los ruidos respiratorios, o silbido en el pecho
- dificultad para respirar, opresión en el pecho, falta de aliento o dolor en el pecho
- molestias al respirar
- respiración superficial, respiración fuerte y rápida
- aleteo nasal (las fosas nasales se abren más para aspirar más aire)
- sólo puede hablar en frases cortas o no es capaz de hablar
- color azulado alrededor de los labios o las uñas
- retracciones del tórax, uso de músculos accesorios
- pulso rápido

El Albuterol deberá administrarse según lo establece el "*Procedimiento para la administración de albuterol en caso de emergencia*" que se encuentra anexo.

Entre las posibles complicaciones que se presentan como resultado de este tratamiento, se incluyen: nerviosismo, agitación (temblores), dolor de cabeza, mareos, sequedad o irritación de boca/garganta, dolor de garganta, tos, náuseas, vómitos, problemas para dormir (insomnio), ronquera, secreción o congestión nasal, dolor muscular, o diarrea.

- ☐ **Doy mi consentimiento para que se le administre el albuterol.**
- ☐ **No doy mi consentimiento para que se le administre el albuterol.**
- ☐ **Mi hijo ya tiene un formulario de consentimiento en el expediente y Albuterol en la escuela.**

Padre / Madre / Tutor/a

Fecha

Profesor/a

Grado Escolar

School Name: _____

STOCK ALBUTEROL DOCUMENTATION LOG

Date: / /

Student's Name (Last, First) _____

DOB: / /

Gender: ☐ Male ☐ Female ☐ Other

Ethnicity: ☐ Hispanic / Latino
 ☐ non-Hispanic / non-Latino

Race: ☐ American Indian / Alaska Native
 ☐ Asian
 ☐ Black / African American
 ☐ Native Hawaiian / Pacific Islander
 ☐ White

Did the student have a known diagnosis of asthma before this day?
☐ Yes ☐ No ☐ Do not know

Trained Staff's Name (Last, First) _____

Location where symptoms developed _____

_____ ☐ A.M. ☐ P.M.
Time of day albuterol was administered

_____ (Puffs)
Number of puffs of albuterol administered

Disposition Status:
☐ Returned to class
☐ Sent home with caregiver
☐ Called 911 and NO EMS transport
☐ Called 911 and transported via EMS

Standing Order Authority (Physician Name) _____

EMS Agency Name (If applicable) _____

_____ ☐ A.M. ☐ P.M.
Time 911 was called (If applicable)

_____ ☐ A.M. ☐ P.M.
Time EMS arrived (If applicable)

Name of hospital student was transported to _____

Comments:

Date: / /

Student's Name (Last, First) _____

DOB: / /

Gender: ☐ Male ☐ Female ☐ Other

Ethnicity: ☐ Hispanic / Latino
 ☐ non-Hispanic / non-Latino

Race: ☐ American Indian / Alaska Native
 ☐ Asian
 ☐ Black / African American
 ☐ Native Hawaiian / Pacific Islander
 ☐ White

Did the student have a known diagnosis of asthma before this day?
☐ Yes ☐ No ☐ Do not know

Trained Staff's Name (Last, First) _____

Location where symptoms developed _____

_____ ☐ A.M. ☐ P.M.
Time of day albuterol was administered

_____ (Puffs)
Number of puffs of albuterol administered

Disposition Status:
☐ Returned to class
☐ Sent home with caregiver
☐ Called 911 and NO EMS transport
☐ Called 911 and transported via EMS

Standing Order Authority (Physician Name) _____

EMS Agency Name (If applicable) _____

_____ ☐ A.M. ☐ P.M.
Time 911 was called (If applicable)

_____ ☐ A.M. ☐ P.M.
Time EMS arrived (If applicable)

Name of hospital student was transported to _____

Comments:

School Logo

MEDICATION FOR FIELD TRIP

Student's Name: _____ Date: _____

Medication: _____ Time to be given: _____

Dose: _____ Route of Administration: _____

Prescriber: _____ Rx #: _____

Pharmacy Name & Phone: _____

I agree to provide to the above-named student, at the appointed time, the above-named medication, which is contained in this envelope.

Name: _____ Title: _____



DIOCESE OF TUCSON CATHOLIC SCHOOLS

PERMISSION FOR A STUDENT TO SELF-ADMINISTER AN INHALER (Permission to be granted only in rare and unusual circumstances. Must be renewed annually.)

Name: _____ Grade: _____ Teacher/Coach: _____

Name of Medication: _____ Amount to Be Taken: _____

Time to Be Taken: _____ Circle One: Daily As Needed

Duration of Treatment: From _____ To _____

I hereby authorize my child _____ to self-administer the above-named inhaler.
(Name)

Any Known Drug or Food Allergy _____

Request for Self-Administration of a Prescription Inhaler at School

Decisions to self-administer an inhaler at school will be made on a case-by-case basis. To initiate self-administration use of an inhaler will require a conference with the principal, school health personnel and the parent.

This inhaler is to be furnished by parent/guardian and is to be labeled in an original prescription container with student's name, name of medication, amount to be taken, time of day to be taken, and duration of treatment. This form signed by the prescribing medical provider must be kept with the inhaler.

I have instructed my child NOT to make available, provide, or give this medication to any other student. My child will immediately report the loss or theft of this medication. I understand that I am liable for any consequences.

Reason for taking medication _____

As ordered by _____ MD DO PA NP

Medical Provider's Signature _____

Date _____

Parent/Guardian's Signature _____

Date _____

Pharmacy and Prescription Number _____

Lot Number & Expiration Date _____

Important Information--Please Read.

Parents assume full responsibility for the self-administration of any medication at school. The student and the parent are jointly responsible to assure that all necessary permission forms are kept with the medication at all times and that the medication is properly administered. The student is responsible to assure that the medication is not used by another student. It is against school policy for any student to share, distribute, or sell any medication. Policy dictates that any such action on the part of the student will result in severe disciplinary or legal action. The school assumes no responsibility for monitoring self-administered medications or any side effects thereof. The school health service will assist only with those medications deposited in the school health office.

Permission to carry and self-administer an inhaler should be given primarily to student athletes who might need this medication to participate in after-school sports when the health office is closed. It remains school policy that all medication taken during the hours when the health office is open is to be taken in the health office under supervision.

This original copy is to be maintained in the school health office and filed in the student's health record at the end of the school year. A copy is to be given to the teacher/coach and a copy is to be kept with the medication at all times.



DIOCESE OF TUCSON CATHOLIC SCHOOLS

PERMISSION FOR A STUDENT TO SELF-ADMINISTER AN EPI-PEN (Permission to be granted for current school year only. Must be renewed annually.)

School: _____ School Year _____ / _____

Name: _____ Grade: _____ Teacher/Coach: _____

I hereby authorize my child _____
(Name)
to self-administer an EpiPen as needed for
a potentially life-threatening allergic reaction to:

Pharmacy and Prescription Number

Lot Number & Expiration Date

Physician's Statement

- I certify that this student has a potentially life threatening condition/illness that requires medication to be available at all times. This student has been instructed in the proper method of self-administration of this medication and is capable of self-administration at the appropriate times.
- This student has been instructed not to share the medication with anyone.
- I understand that the school shall incur no liability as a result of any injury arising from the self-administration or misuse of this medication by the pupil; or if the pupil does not have the medication with him/her when needed; or if the medication carried by the pupil has passed its expiration date.
- This form is valid for the school year indicated above, and permission must be renewed each year. Permission may be revoked if the pupil proves to be incapable of safely self-administering the medication at school.
- This child and the parent/guardian are aware of the above information.

Date _____ Physician's Signature _____

Parent's Statement

As the parent/guardian of the above-named student, I acknowledge that the above-named school, its employees, or agents shall incur no liability as a result of any injury arising from the self-administration of the above-named medication by my child. I agree to hold harmless the school and its employees or agents against any claims arising out of such self-administration.

Date _____ Parent's/Guardian's Signature _____

A copy of this form is to be kept with the medication carried by the student. This original form is to be maintained in the school health office and filed in the student's health record at the end of the school year.

Important Information--Please Read.

It is against school policy for any student to share, distribute, or sell any medication. Policy dictates that any such action on the part of the student will result in severe disciplinary or legal action.

DIOCESE OF TUCSON SCHOOLS

School:

School Year:

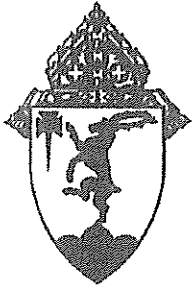
The following checklist is designed to train the principal's designee(s), named on the reverse side, in the administration of medications to students. Upon completion of instruction, the trainee shall write his/her signature in the space provided, thereby acknowledging that the medication administration procedure has been fully explained and that s/he agrees to strictly follow these procedures when administering medications to students.

Directions: 1) Print the name of person being trained and the date of training.

- 2) Check each area of training when instruction and/or demonstration have been satisfactorily completed.
- 3) Person being trained must sign the checklist in the appropriate box.
- 4) Nurse responsible for providing the training must also sign the checklist in the appropriate box.
- 5) Original of this document must be kept on file with the School Year Medication Record book in the school.

[illegible]

* 1) Right Person	2) Right Medicine	3) Right Time	4) Right Dose	5) Right Route	6) Right Documentation	7) Right evaluation
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Diocese of Tucson Catholic Schools

MEDICATION INCIDENT REPORT

School _____ Date _____

Name of Student _____ Age _____

Staff Person Responsible _____

1. Description of Incident--Describe exactly what occurred, including time, etc.

2. Student response--Describe what symptoms/behavior occurred in the student.

3. Steps taken after incident:

School Nurse informed Y/N Name _____ Time _____

Principal notified Y/N Name _____ Time _____

Physician called Y/N Name _____ Time _____

Poison Control called Y/N Name _____ Time _____

Parent/Other called Y/N Name _____ Time _____

4. What steps will be taken to prevent this type of incident from happening another time?

Signature/Staff

Signature/Principal

Learn More About ...

If you would like more information about pharmaceutical disposal, you may want to visit some of these links:

There are new federal guidelines for the proper disposal of unused, unneeded, or expired prescription drugs.
www.whitehousedrugpolicy.gov/publications/pdf/prescrip_disposal.pdf

The United States Geological Survey (USGS) has gathered sampling data that confirms the presence of pharmaceuticals in aquatic and terrestrial environments.
toxics.usgs.gov/regional/emc.html

The United States Environmental Protection Agency (EPA) has compiled information on potentially negative environmental impacts.
www.epa.gov/ppcp

Wastewater Agencies in the Los Angeles, Orange County, and San Diego area sponsored a "No Drugs Down the Drain" initiative.
www.nodrugsdownthedrain.org

Most Arizona cities have collection events for household hazardous waste, including medicines. Check with your local solid waste program or visit:
www.azrecycles.gov

Contacts for Further Information



Janice K. Brewer, Governor
Henry R. Darwin, Director

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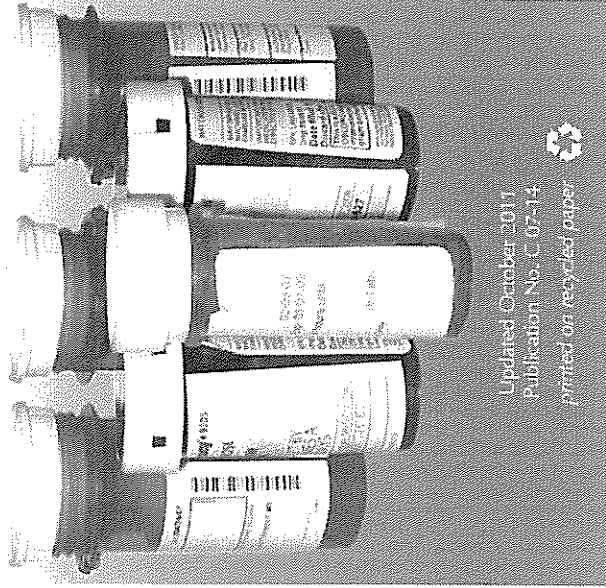
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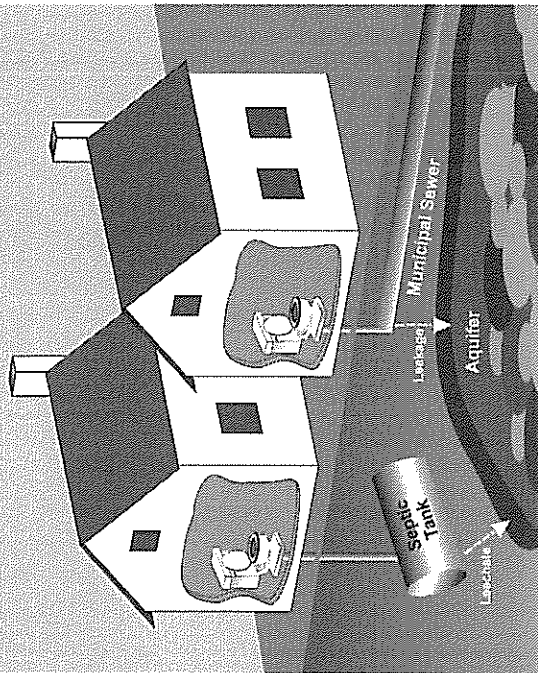
Prescription Drug Disposal...

A Pain in the Drain



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No Drugs Down the Drain



If you're like most people, you have accumulated a collection of prescription drugs and other pharmaceuticals that are no longer needed. Once it was common practice to flush these medications down the toilet. Many prescription and nonprescription drugs and chemicals in personal care products (PPCPs) are found at trace levels in treated wastewater discharged from sewage treatment plants. These PPCPs are found in human wastes or may be directly released to the sewer for disposal.

We now know that some of these substances are bad for our environment. As illustrated in the picture, the PPCPs can pass through sewage treatment plants and septic tanks into surface waters, soils, and the groundwater. The federal government has released new guidelines which are designed to reduce the diversion of prescription drugs while also protecting the environment.

New Federal Prescription Drug Disposal Guidelines Urge You To:

- Take unused, unneeded or expired prescription drugs out of their original containers.
- Mix the prescription drugs with an undesirable substance like coffee grounds or kitty litter, and put them in impermeable, nondescript containers such as empty cans or sealable bags, further ensuring that the drugs are not diverted or accidentally ingested by children or pets.
- Throw these containers in the trash.
- Flush prescription drugs down the toilet *only* if the accompanying patient information specifically instructs that it is safe to do so.
- Return unused, unneeded or expired prescription drugs to pharmaceutical take-back locations for safe disposal. Ask your local pharmacy about pharmaceutical take-back programs.

Facts About Prescription Drug Disposal

- Drugs can be scavenged and illegally sold, or could poison children and animals.
- Unused medications improperly disposed of can harm you and your environment.
- When drugs are flushed, they may not be broken down by the sewage treatment facilities and septic tank systems and can enter the soil, surface water and groundwater.
- Research studies have shown that exposure to drugs found in waterways is having a adverse impacts on certain species of fish and other aquatic life.
- Pollution prevention - the elimination or minimization of the pollution source - is preferable to cleaning up the environment. Thereby minimizing both public cost and human and ecological exposure.

Why Should I Take the Time To Do This?

PPCPs in the environment illustrate the immediate connection of the actions/activities of individuals with their environment. Properly disposing of unwanted medications may be inconvenient, but there are some very compelling reasons to do this in a safe and responsible manner.

● *It's your environment –*

Please don't flush!

Drugs that are flushed down the toilet may pass through sewage treatment plants and septic tanks. These substances are released into waterways with the waste water which can lead to adjacent soil and ground water. Similarly, septic tanks systems may release the pharmaceuticals directly into the soil and eventually into the groundwater. Proper disposal of drugs is a straightforward way for individuals to prevent pollution.

● *Read the product label!*

Certain antimicrobial agents in personal care products, such as Triclosan, can also enter the environment via the drain. PPCPs containing Triclosan will be listed under Active Ingredients on the label.

● *You can make a difference!*

Children, pets or scavenging animals could find the medication and ingest it. Drugs could be scavenged and illegally sold. Take action to minimize the threat of accidental poisoning or drug abuse. Let's take precautions now to avoid harm to future generations and the environment. Your participation is appreciated!

CHILD ABUSE REPORT FORM

DIOCESE OF TUCSON

Report to Law Enforcement: Call 911

Report to DCS: Call 888-SOS-CHILD (omit D on cell phone)
(888-767-2445)

DATE AND TIME REPORTED:

AGENCY OR AGENCIES TO WHICH THE
REPORT WAS MADE:

NAME OF PERSON MAKING THE REPORT AND PARISH/SCHOOL/AGENCY:

BEST PHONE NO. (*of person
making the report*):REPORT NUMBER (FOR EACH
AGENCY TO WHICH
REPORTED):RESPONDING OFFICER OR
DCS SPECIALIST:

AS REQUIRED IN A.R.S. §13-3620, THE REPORT SHOULD INCLUDE:

- The names and addresses of the minor and his/her parents or person or persons having custody of such minor, if known.
- The minor's age and the nature and extent of his/her injuries or physical neglect, including any evidence of previous injuries or physical neglect.
- Any other information that such person believes might be helpful in establishing the cause of the injury or physical neglect.

PARENT, GUARDIAN OR CUSTODIAN'S NAME

ADDRESS (No., Street, City, State, ZIP)

MOBILE OR HOME PHONE NO.

WORK PHONE NO.

PARENT, GUARDIAN OR CUSTODIAN'S NAME

ADDRESS (No., Street, City, State, ZIP)

MOBILE OR HOME PHONE NO.

WORK PHONE NO.

CHILD'S NAME (*if other children are involved, add their names below*)

DATE OF BIRTH

CHILD'S ADDRESS (No., Street, City, State, ZIP)

CHILD'S NAME

DATE OF BIRTH

CHILD'S ADDRESS (No., Street, City, State, ZIP)

CHILD'S NAME

DATE OF BIRTH

CHILD'S ADDRESS (No., Street, City, State, ZIP)

CHILD'S NAME

DATE OF BIRTH

CHILD'S ADDRESS (No., Street, City, State, ZIP)

ALLEGATION OF ABUSE AND/OR NEGLECT: (Describe the information that led to a reasonable suspicion of abuse, neglect or maltreatment, e.g. nature and extent of the child's injuries, evidence of previous injuries or physical neglect, or oral report of abuse or neglect from the child, youth or other person. Provide information in chronological order as much as possible, including the results of the report to law enforcement and DCS. Because this information is critical, please print or write legibly. You may also complete this document electronically or submit additional pages that have been typed or composed on a word processor. Thank you.)

INTERNET-BASED HEALTH PROMOTION RESOURCES

This list represents only a small part of what is available, but it provides a way to get started. Many of the sites have not only lesson plans but also free posters and other materials.

- **University of Arizona Nutrition Network** provides nutrition and physical activity education and interventions are delivered to youth and adults in community programs and schools. Direct education, partner trainings, technical assistance, and other resources are used to promote healthy eating and physical activity: <http://uanutritionnetwork.org/>
- **PBS Learning Media** has a vast network of resources for health and fitness education. It is part of the PBS.org website: <https://az.pbslearningmedia.org/>
- The **American Diabetes Association** website is very comprehensive and covers education, diet, activity, research, and much more: <http://www.diabetes.org/>
- The **American Heart Association's** website has The Kids Heart Challenge that prepares kids for success by supporting both their **physical and emotional** well-being. These events can be incorporated in physical education classes. The AHA website is: <http://american.heart.org/kidsheartchallenge/>
- The **American Cancer Society** has tobacco-free resources and a wealth of information on all forms of cancer available on their website: <https://www.cancer.org/>
- The **Centers for Disease Control and Prevention** also has tobacco-free resources on their website: <https://www.cdc.gov/tobacco/index.htm>
- The **Walk On!** challenge is a program that teaches fourth- and fifth-graders easy ways to eat better, to get enough exercise so that they can be strong and healthy. It's a fight against childhood obesity. The students participate as a class once their teacher has enrolled them in the challenge. The website is: <https://walkonaz.com/>
- **Choose My Plate** is a nutrition-oriented website with several lesson ideas. The website is: <https://www.choosemyplate.gov/kids>
- **Always Changing and Growing Up Program** provides puberty lessons for 5th grade and up. website: www.pgschoolprograms.com.
- **Action for Healthy Kids** is the only nonprofit organization formed specifically to address the epidemic of overweight, undernourished, and sedentary youth by focusing on changes at school. The website is: <http://www.actionforhealthykids.org/>
- **5 A Day for Better Health** program is the nation's largest public-private nutrition education initiative. The website is: <https://www.fruitsandveggiesmorematters.org/>

- The **National Dairy Council** website includes recent health and nutrition research reviews, downloadable educational materials, and more: <https://www.nationaldairycouncil.org/>
- There are many additional health education and information resources available on the websites of the **National Association of School Nurses (NASN)**, **School Nurse Organization of Arizona (SNOA)**, and the **Arizona School Nurse Consortium**. Their websites are: www.nasn.org, <https://snoa.org/> and <http://azschoolnurse.org/>
- Your local fire and police departments may also have speakers available to talk about water and bicycle safety, drug abuse prevention, and other topics.