ARIZONA ARTS ACADEMY

9502 S. Hwy 92
Hereford, AZ 85615

info@azarts.academy

520-210-5400
www.azarts.academy

STUDENT HEALTH RECORD

Student Name (printed): ____ Date of Birth: ____________________

Parent/Guardian Name (printed): _________________________________ Contact Number: _________________

The school requires a doctor's order for all prescription medications, including some over-the-counter medications which need to be administered during the school year. If it is necessary for your child to receive medication at school, please note these key points. 1. The medication must be ordered for your child by a primary care physician licensed to practice in Arizona, 2. All medications (including inhalers) need to be provided in the original prescription bottle/box with a pharmacy label that includes the student's name, name of medication, amount to be given, and name of the prescribing physician.

A. ☐ My child **DOES NOT** have any health concerns or conditions. Review all sections before checking. If nothing else applies, skip to section E for signature.

B. **Life-Threatening Conditions** (check all appropriate boxes below):

☐ My child has the following life-threatening health condition(s):

- ☐ **Life-threatening allergy with Epi-Pen** (epinephrine) prescribed

  List the life-threatening allergens: ____

- ☐ **Asthma with rescue inhaler** needed at school
- ☐ **Diabetes:** ☐ Type 1 OR ☐ Type 2
- ☐ **Seizure disorder** Type: ___________________________ Rescue medication prescribed: ☐ Yes ☐ No
- ☐ **Other serious health condition(s)** (e.g. heart or lung conditions, blood disorders, cancer, transplant, etc.)

  Describe: ____

C. **Other Health Conditions** (check appropriate boxes below):

☐ Other allergies (medicine, bees, food, etc.): ____

☐ Gastrointestinal conditions (Celiac, IBS, encopresis, etc.): ____________________________

☐ Neurological conditions (ADHD, Autism, TBI, migraines, etc.): _________________________

☐ Vision or Hearing concerns: ____

☐ Mental or Behavioral health concerns: ______________________________________

☐ Other health concerns: ____

D. **Medications:** Includes prescription, supplements, and over the counter medications

Does your child need to take medication daily or as needed at school? ☐ Yes ☐ No

If yes, please list: ____

E. **Signature:**

I understand that the information provided will be shared with appropriate school staff who need to know in order to provide for the health and safety of my student. I understand the nurse may communicate with my child's healthcare provider for any questions or clarifications to the medical order, medical diagnosis, or the medical plan of care.

____

Parent/Guardian Name (signature) Date

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Permission to Administer OTC Medication

Student Name (printed): ____ Grade: _____

I give Arizona Arts Academy permission to (check all that apply):

- ☐ Administer any OTC medications
- ☐ Acetaminophen and/or Ibuprofen (Middle/High school students only)
- ☐ Contact parent before administering any medication

My child is allergic to:

____ None

___________________________ If exposed, __________________________ action is to be taken.

___________________________ If exposed, __________________________ action is to be taken.

___________________________ If exposed, __________________________ action is to be taken.

My child has the following medical concern(s) that AAA staff should be aware of:

____

Previous school history:

____ IEP ____ 504

____ Disciplinary action for fighting/hurting a teacher or student. Explain: ___________________________

____ History of self-harm. Explain: ____

____
Parent Name (printed) Date

____
Parent Name (signed)

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PHYSICIAN'S ORDER FOR MEDICATION AT SCHOOL

Student Name (printed): ____ Date of Birth: ______________________

Medication is ordered to be given to a student at school only when absolutely necessary. Whenever possible, the parent and physician are urged to design a schedule for giving medication outside of school hours. If this is not possible, it must be understood by the parent that the medication will be dispensed by designated school staff if the school nurse is not present. The school accepts no responsibility for untoward reactions when the medication is dispensed in accordance with the physician's directions.

Will this medication be dispensed during school hours? ☐ Yes ☐ No
If yes, give diagnosis and reason: ____

Medication name: ____ Time to be given: ☐ Lunch ☐ Hour _______ ☐ As Needed
Dose to be given: _________________________ Dosage form: ________________________ Mode of administration: __________________
Duration without subsequent order: ☐ Weeks ______ ☐ Months ______ ☐ School Year ______ ☐ Other: _______________________

____
Health Care Provider Name/Stamp (printed) Phone Fax

____
Health Care Provider Name (signature) Email Date

********** **THIS AUTHORIZATION IS GOOD FOR THE CURRENT SCHOOL YEAR ONLY** **********

Parent/Guardian's Permission

I request that the school nurse or designated Arizona Arts Academy staff member be permitted to dispense to my child,
(Name of Child) ______________________________, the medication prescribed by *(Name of Physician)* ____________________________
for a period from ________________ to ________________.

The medication is to be furnished by me in the original container labeled by the pharmacy. The pharmacy label should include the name of the student, the name of the medication, the name of the prescribing physician, the dosage amount to be taken, and the time of day to be taken.

I understand that my signature indicates my understanding that the school accepts no liability for untoward reactions when the medication is administered in accordance with the physician's directions. I request that the school nurse or designated staff be permitted to discuss my child's medical issues with healthcare providers and administer the medication to my child.

This authorization is good for the ___________________________ school year only.

____
Parent/Guardian Name (printed) Date

____
Parent/Guardian Name (signature) Contact Number Email Address

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ASTHMA TREATMENT PLAN & MEDICATION REQUEST

Student Name (printed): ___________________________________ School Year: ____________________________

The student named above has asthma and may need to take medication at school. The treatment plan for managing asthma at school is as follows (check all that apply):

Diagnosis: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

☐ Administer rescue medication if student experiences symptoms (coughing, difficulty breathing, wheezing, chest tightness)

Will this medication be dispensed during school hours? ☐ Yes ☐ No

If yes, give diagnosis and reason: ____

Drug and Dosage Form	Dose, Time, and Mode of Administration
☐ Albuterol inhaler ☐ with spacer	☐ 2 (or ____) puffs by mouth 5-20min prior to exercise, as needed (may repeat with 2) ☐ 2 (or ____) puffs by mouth every 3-4hr as needed for symptoms ☐ If no relief after treatment, call 9-1-1 and notify appropriate staff ☐ Other:
☐ Albuterol via nebulizer ☐ Levalbuterol via nebulizer ☐ mouth ☐ mask	☐ 1 unit dose every ____ hours as needed for symptoms ☐ May repeat and call 9-1-1 ☐ Other:

☐ Student may carry AND self-administer the medication ordered above

☐ Student may carry AND CANNOT self-administer the medication ordered above

____

Health Care Provider Name/Stamp (printed) Phone Fax

____

Health Care Provider Name (signature) Email Date

*********** THIS AUTHORIZATION IS GOOD FOR THE CURRENT SCHOOL YEAR ONLY ***********

Parent/Guardian's Permission

I request that the school nurse or designated Arizona Arts Academy staff member be permitted to dispense to my child, *(Name of Child)* ____________________________, the medication prescribed by *(Name of Physician)* ____________________________ for a period from _______________ to _______________.

I understand that my signature indicates my understanding that the school accepts no liability for untoward reactions when the medication is administered in accordance with the physician's directions. I request that the school nurse or designated staff be permitted to discuss my child's medical issues with healthcare providers and administer the medication to my child.

This authorization is good for the __________________________ school year only.

____

Parent/Guardian Name (printed) Date

____

Parent/Guardian Name (signature) Contact Number Email Address

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EPINEPHRINE TREATMENT PLAN & MEDICATION REQUEST

Student Name (printed): ___________________________________ School Year: ____________________________

The student named above may require treatment to prevent and/or treat anaphylaxis. The student may have an anaphylactic response to ____ and should provide 2 epinephrine auto-injectors.

Symptoms of anaphylaxis may include breathing difficulties, facial/throat swelling or tingling, hives, rash, itching, stomach cramps, dizziness, nausea/vomiting, or swelling.

Call 911 at the time epinephrine is given and notify parent/guardian.

The treatment plan for preventing/treating anaphylaxis at school is as follows (check all that apply):

- ☐ Benadryl (Dose amount/type: ______________) ☐ Epinephrine auto-injector 0.3mg ☐ Epinephrine auto-injector 0.15mg
- ☐ Repeat dose of epinephrine may be given if: ____
- ☐ This student also has asthma and may be at higher risk for developing anaphylaxis
- ☐ Yes ☐ No Student may carry epinephrine auto-injector
- ☐ Yes ☐ No Student may self-administer epinephrine auto-injector

____

Health Care Provider Name/Stamp (printed) Phone Fax

____

Health Care Provider Name (signature) Email Date

************ THIS AUTHORIZATION IS GOOD FOR THE CURRENT SCHOOL YEAR ONLY ************

Parent/Guardian's Permission

I request that the school nurse or designated Arizona Arts Academy staff member be permitted to dispense to my child, *(Name of Child)* ____________________________, the medication prescribed by *(Name of Physician)* ____________________________ for a period from _______________ to _______________.

I understand that my signature indicates my understanding that the school accepts no liability for untoward reactions when the medication is administered in accordance with the physician's directions. I request that the school nurse or designated staff be permitted to discuss my child's medical issues with healthcare providers and administer the medication to my child.

This authorization is good for the __________________________ school year only.

____

Parent/Guardian Name (printed) Date

____

Parent/Guardian Name (signature) Contact Number Email Address