Taos Municipal Schools
taosschools.org

STUDENT HEALTH HISTORY

TO BE FILLED OUT BY ALL (NEW AND RETURNING) and RETURNED IMMEDIATELY

PRINT Student Name_____

Entering Grade in Fall _____ ☐Returning Student ☐New Student

Date of Current Physical Exam: _____ Date of Next Physical Exam Appointment: _____

☐ **NO,** my child / ward has no special health concerns and does not require medication in school.

☐ **YES**, my child/ward is diagnosed with a special health concern that may require routine or emergency medication and treatment while in school.

Check ALL that apply, and take ***REQUIRED CARE PLAN*** *to Medical Provider to Complete*.

☐ **Asthma:** ☐ Intermittent ☐Exercise Induced ☐Uses an Inhaler *Asthma Action Plan Required*

☐ **Diabetes:** ☐Type 2 ☐Type 1 ☐Uses a pump / insulin *Diabetes Management Plan Required*

☐ **Seizure:** Type: *Seizure Care Plan Required*

☐ **Allergies:** ☐Food ☐Insect ☐Latex ☐Medication *Allergy Care Plan Required*

List Allergen(s): _____

Treatment Prescribed: ☐None ☐Antihistamine ☐Epinephrine Auto-injector:

☐ **History of Concussion**: Date Occurred: _____ Cleared by Medical Provider ☐YES ☐NO

☐ Other health concerns, history or information you want to share:

If you **CHECKED** ANY of the above, a **Care Plan and back-up medication** MUST be provided to the school. **Care Plans** can be downloaded from taosschools.org under forms (*instructions posted on back of this sheet)*.

The Care Plan must be completed and signed by the medical provider *and* have parent/guardian signature on bottom. Submit to the Nurse's Office with the **required back-up medications** as indicated below:

- Inhaler: Two (2) inhalers with one (1) spacer (required);
- Epinephrine: Two (2) auto-injectors two (1) twin pack);
- Diabetes: All diabetic supplies, including pump supplies, Glucagon, snacks, and insulin pen;
- Seizure: Two doses of emergency medication for prolonged seizure as prescribed by medical provider.

This form completed and signed (both sides), along with the Care Plan, is required for treatment of the above check health concerns and administration of required medications.

COMPLETE OTHER SIDE

Ranchos	Arroyos	Taos Middle	Taos High/Chrysalis	Enos/ Cyber Magnet
Lisa	Carmela	Kathleen	April	Krissy
575-737-6153.	575-737-6175.	575-737-6000.	575-751-8074.	575-737-6075.

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Parent Consent and Student Self-Medication Agreement

Print Student Name: _____Grade: _____

As the parent/guardian of the above student, I request that my child be permitted to carry and self-administer his/her required medications as directed by the Medical Provider. I understand it is my responsibility to provide required medications and agree to provide backup medication to the Health Office for emergency care for special health concerns in addition to providing medication for my child to carry at all times. I will provide medication in the original unopened package with pharmacy label attached and replace medication in a timely manner prior to expiration date. I understand that medication must be picked up at the end of the school year and if not picked up or expired, medication will be discarded as per protocol for disposal. I will notify the school of any changes in my child's health and/or medication needs. Health information may be shared with appropriate staff as necessary including communication between the school nurse and medical provider. I give permission for the alternate contact and school representative to act on my behalf, and that of my child, until I am contacted and available.

Parent/Guardian Name: #1_____Parent/Guardian Name: #2_____

Home: #1_____#2: _____

Cell: #1_____#2: _____

Work: #1_____#2: _____

Physical Address: #1_____#2; _____

Provide alternate contact available and willing to stand in for parent/guardian until they are reached and available:

Alternate Contact Name:_____

Relationship:_____ Phone:_____

Parent/Guardian Signature:_____Date_____

Student Agreement and Signature:

I,_____agree I will: •not allow another student to use my medication. •check to make sure that my emergency medication is labeled with my name. •be aware of the expiration date of medication and replace before expired •keep my medication with me at all times and take to all activities and off campus events •report to teacher, coach, administration if I come in contact with my triggers/ allergens whether or not I am having symptoms •go to the Office, accompanied by someone, when I have used my emergency medication or am having symptoms •as best as possible avoid exposure to risks to my health and safety •follow school policy and my medical provider's instructions and directives on my emergency plan of care.

Student's Signature:_____Date_____

Student Cell_____

Instructions to download supplemental forms from the intranet: Log onto Taos Municipal Schools Home Page (www.taosschools.org): Scroll to additional links: click link for Medical Forms folder.

NOTE: The Medical Exam Form must be signed by the Medical Provider even when they provide and attach their own form. Care Plans must be completed and signed by medical provider *and* parent. Any medication not included in a Care Plan must submit the Medication Authorization form completed by medical provider and signed by parent in order to be administered.

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