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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: ___________________________

- over -
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:

<table>
<thead>
<tr>
<th>NAME</th>
<th>TITLE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

A - 1
# Emergency, Information and Immunization Record Card

<table>
<thead>
<tr>
<th>Child's Name:</th>
<th>Date Enrolled:</th>
<th>Updated:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Address (#, Street, City, State, Zip Code):</td>
<td>Date Disenrolled:</td>
<td></td>
</tr>
<tr>
<td>Home Phone:</td>
<td>Date of Birth:</td>
<td>Sex: ☐ male ☐ female</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mother or Guardian Name:</th>
<th>Home Address (#, Street, City, State, Zip Code):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cell Phone (optional):</td>
<td>Contact Telephone Number:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Father or Guardian Name:</th>
<th>Home Address (#, Street, City, State, Zip Code):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cell Phone (optional):</td>
<td>Contact Telephone Number:</td>
</tr>
</tbody>
</table>

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.)

<table>
<thead>
<tr>
<th>Name:</th>
<th>Contact Telephone Number:</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

If Medical care is necessary, call:

<table>
<thead>
<tr>
<th>Health Care Provider*</th>
<th>Name:</th>
<th>Contact Telephone Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

* 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:**

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:

- Copy of current official documented immunization record attached
- Religious Beliefs exemption form signed by parent/guardian attached
- Medical Exemption form signed by physician and parent/guardian attached
- Signed Laboratory Proof of Immunity form attached

<table>
<thead>
<tr>
<th>Notification of immunizations needed sent to Parent(s) or Guardian(s):</th>
<th>mo /day /yr</th>
<th>mo /day /yr</th>
<th>mo /day /yr</th>
</tr>
</thead>
<tbody>
<tr>
<td>Updated immunizations received and attached:</td>
<td></td>
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</tbody>
</table>

| |
|---|---|---|
| |
| |

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:

- No
- Yes

Is child usually susceptible to infections and if so, what precautions need to be taken?  
If yes, list precautions:

- No
- Yes

Is child subject to convulsions and what should be our procedure if one occurs?  
If yes, specify procedure:

- No
- 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:

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: |

G:\Forms\Emergency Information and Immunization Record Card  (9/11)  
B - 1
<table>
<thead>
<tr>
<th>Grade</th>
<th>Entered</th>
<th>School</th>
<th>Grade</th>
<th>Withdrawn</th>
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</table>

**HEALTH RECORD**

<table>
<thead>
<tr>
<th>Date</th>
<th>Visual Acuity FAR (B)</th>
<th>Visual Acuity NEAR (optional)</th>
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<tbody>
<tr>
<td>R</td>
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<tr>
<td>L</td>
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<table>
<thead>
<tr>
<th>Date</th>
<th>Visual Acuity FAR (R)</th>
<th>Visual Acuity NEAR (optional)</th>
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<td>R</td>
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<td>L</td>
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<tr>
<th>Date</th>
<th>Visual Acuity FAR (L)</th>
<th>Visual Acuity NEAR (optional)</th>
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<td>R</td>
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<td>L</td>
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<tr>
<th>OCULAR ALIGNMENT</th>
<th>DEPTH</th>
<th>COVERTED</th>
<th>COLOR DEFICIENT</th>
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**Diocese of Tucson Catholic Schools**

**SPECIAL TESTS**

<table>
<thead>
<tr>
<th>Date</th>
<th>TB</th>
<th>DTaP / DTP / DT</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>Td / Tdap</td>
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<tr>
<td></td>
<td></td>
<td>IPV / OPV</td>
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</table>

**OTHER IMMUNIZATIONS**

<table>
<thead>
<tr>
<th>Date</th>
<th>Date</th>
<th>MMR</th>
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<tr>
<th>Date</th>
<th>Date</th>
<th>Hib</th>
<th>Hep B</th>
<th>Hep A</th>
<th>Varicella</th>
<th>Meningococcal</th>
<th>HPV</th>
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</table>
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)

- over -
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.
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: ___________________ Date: ______________ Res: ______________

Cocci: Date: ______________ Res: ______________

Tbc: Date: ______________ Res: ______________

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 # _______

- over -
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?

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

Operations

Year

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

- over -
2018-19 ANNUAL PREPARTICIPATION PHYSICAL EVALUATION
(The parent or guardian should fill out this form with assistance from the student-athlete) Exam Date: ______________

<table>
<thead>
<tr>
<th>Name: ____________________________</th>
<th>In case of emergency contact:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Address: ____________________</td>
<td>Name: ________________________</td>
</tr>
<tr>
<td>Phone: __________________________</td>
<td>Relationship: ________________</td>
</tr>
<tr>
<td>Date of Birth: _________________</td>
<td>Phone (Home): ________________</td>
</tr>
<tr>
<td>Age: ___________________________</td>
<td>Phone (Work): ________________</td>
</tr>
<tr>
<td>Gender: _________________________</td>
<td>Phone (Cell): ________________</td>
</tr>
<tr>
<td>Grade: __________________________</td>
<td>Name: ________________________</td>
</tr>
<tr>
<td>School: _________________________</td>
<td>Relationship: ________________</td>
</tr>
<tr>
<td>Sport(s): _______________________</td>
<td>Phone (Home): ________________</td>
</tr>
<tr>
<td>Personal Physician: _____________</td>
<td>Phone (Work): ________________</td>
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<tr>
<td>Hospital Preference: ____________</td>
<td>Phone (Cell): ________________</td>
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</table>

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

<table>
<thead>
<tr>
<th>Y</th>
<th>N</th>
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</thead>
<tbody>
<tr>
<td>1) Has a doctor ever denied or restricted your participation in sports for any reason?</td>
<td>☐</td>
</tr>
<tr>
<td>2) Do you have an ongoing medical conditional (like diabetes or asthma)?</td>
<td>☐</td>
</tr>
<tr>
<td>3) Are you currently taking any prescription or nonprescription (over-the-counter) medicines or supplements? (Please specify):</td>
<td>☐</td>
</tr>
<tr>
<td>4) Do you have allergies to medicines, pollens, foods or stringing insects? (Please specify):</td>
<td>☐</td>
</tr>
<tr>
<td>5) Does your heart race or skip beats during exercise?</td>
<td>☐</td>
</tr>
<tr>
<td>6) Has a doctor ever told you that you have (check all that apply):</td>
<td>☐</td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td>☐</td>
</tr>
<tr>
<td>A Heart Murmur</td>
<td>☐</td>
</tr>
<tr>
<td>High Cholesterol</td>
<td>☐</td>
</tr>
<tr>
<td>A Heart Infection</td>
<td>☐</td>
</tr>
<tr>
<td>7) Have you ever spent the night in a hospital?</td>
<td>☐</td>
</tr>
<tr>
<td>8) Have you ever had surgery?</td>
<td>☐</td>
</tr>
<tr>
<td>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)</td>
<td>☐</td>
</tr>
<tr>
<td>10) Have you had any broken/fractured bones or dislocated joints? (If yes, check affected area in the box below in question 11)</td>
<td>☐</td>
</tr>
<tr>
<td>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)</td>
<td>☐</td>
</tr>
<tr>
<td>□ Head</td>
<td>□ Neck</td>
</tr>
<tr>
<td>□ Hand/Fingers</td>
<td>□ Chest</td>
</tr>
<tr>
<td>□ Knee</td>
<td>□ Calf/Shin</td>
</tr>
</tbody>
</table>
12) Have you ever had a stress fracture? □ □
13) Have you ever been told that you have, or have you had an X-ray for atlantoaxial (neck) instability? □ □
14) Do you regularly use a brace or assistive device? □ □
15) Has a doctor told you that you have asthma or allergies? □ □
16) Do you cough, wheeze or have difficulty breathing during or after exercise? □ □
17) Is there anyone in your family who has asthma? □ □
18) Have you ever used an inhaler or taken asthma medication? □ □
19) Were you born without, are you missing, or do you have a nonfunctioning kidney, eye, testicle or any other organ? □ □
20) Have you had infectious mononucleosis (mono) within the last month? □ □
21) Do you have any rashes, pressure sores or other skin problems? □ □
22) Have you had a herpes skin infection? □ □
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”)? □ □
24) Have you ever had a seizure? □ □
25) Have you ever had numbness, tingling or weakness in your arms or legs after being hit, falling, stingers or burns? □ □
26) While exercising in the heat, do you have severe muscle cramps or become ill? □ □
27) Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? □ □
28) Have you ever been tested for sickle cell trait? □ □
29) Have you had any problems with your eyes or vision? □ □
30) Do you wear glasses or contact lenses? □ □
31) Do you wear protective eyewear, such as goggles or a face shield? □ □
32) Are you happy with your weight? □ □
33) Are you trying to gain or lose weight? □ □
34) Has anyone recommended you change your weight or eating habits? □ □
35) Do you limit or carefully control what you eat? □ □
36) Do you have any concerns that you would like to discuss with a doctor? □ □

**Females Only**

38) Have you ever had a menstrual period? □ □
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.

<table>
<thead>
<tr>
<th>Patient History Questions: Please Tell Me About Your Child...</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Has your child fainted or passed out DURING or AFTER exercise, emotion or startle?</td>
<td></td>
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</tr>
<tr>
<td>2) Has your child ever had extreme shortness of breath during exercise?</td>
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<tr>
<td>3) Has your child had extreme fatigue associated with exercise (different from other children)?</td>
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<tr>
<td>4) Has your child ever had discomfort, pain or pressure in his/her chest during exercise?</td>
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<tr>
<td>5) Has a doctor ever ordered a test for your child's heart?</td>
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<tr>
<td>6) Has your child ever been diagnosed with an unexplained seizure disorder?</td>
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</tr>
<tr>
<td>7) Has your child ever been diagnosed with exercise-induced asthma not well controlled with medication?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Family History Questions: Please Tell Me About Any Of The Following In Your Family...</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>8) Are there any family members who had sudden/unexpected/unexplained death before age 50? (including SIDS, car accidents drowning or near drowning)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9) Are there any family members who died suddenly of “heart problems” before age 50?</td>
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<td></td>
</tr>
<tr>
<td>10) Are there any family members who have unexplained fainting or seizures?</td>
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<tr>
<td>11) Are there any relatives with certain conditions, such as:</td>
<td>Y</td>
<td>N</td>
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<tr>
<td>Enlarged Heart</td>
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<tr>
<td>Hypertrophic Cardiomyopathy (HCM)</td>
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<td></td>
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<tr>
<td>Dilated Cardiomyopathy (DCM)</td>
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<td>Heart Rhythm Problems</td>
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<td>Long QT Syndrome (LQTS)</td>
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<td>Short QT Syndrome</td>
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<tr>
<td>Brugada Syndrome</td>
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<tr>
<td>Catecholaminergic Polymorphic Ventricular Tachycardia (CPVT)</td>
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<tr>
<td>Arrhythmogenic Right Ventricular Cardiomyopathy (ARVC)</td>
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<tr>
<td>Marfan Syndrome (Aortic Rupture)</td>
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<tr>
<td>Heart Attack, Age 50 or Younger</td>
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<tr>
<td>Pacemaker or Implanted Defibrillator</td>
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<tr>
<td>Deaf at Birth</td>
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</tbody>
</table>

**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

FORM 15.7-A 07/01/2018

NextCare is the preferred partner of the AIA. It is not required you visit NextCare locations for your healthcare needs.
GUIDE TO ARIZONA IMMUNIZATIONS REQUIRED FOR ENTRY

Child Care or Preschool (birth – 5 years)

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.

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>2 Months</th>
<th>4 Months</th>
<th>6 Months</th>
<th>12 Months</th>
<th>15 Months</th>
<th>18+ Months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis B (Hep B or HBV)</td>
<td>Hep B 1*</td>
<td>Hep B 2</td>
<td>Hep B 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(see pg. 2)</td>
<td></td>
<td></td>
<td>(received at 24 weeks of age or older and by 12 mos of age)</td>
<td></td>
<td></td>
<td>Documented 3 or 4 doses</td>
</tr>
<tr>
<td>Diphtheria, Tetanus, and Pertussis</td>
<td>DTaP 1</td>
<td>DTaP 2</td>
<td>DTaP 3</td>
<td></td>
<td>DTaP 4</td>
<td></td>
</tr>
<tr>
<td>Haemophilus influenza type b (Hib)</td>
<td>Hib 1</td>
<td>Hib 2</td>
<td>Hib 3**</td>
<td></td>
<td>Hib 4**</td>
<td></td>
</tr>
<tr>
<td>(see pg. 2)</td>
<td></td>
<td></td>
<td>(see pg. 2)</td>
<td></td>
<td>(see pg. 2)</td>
<td>Documented 3-4 doses</td>
</tr>
<tr>
<td>Poliomyelitis (Polio) (IPV or OPV)</td>
<td>Polio 1</td>
<td>Polio 2</td>
<td></td>
<td></td>
<td>Polio 3</td>
<td></td>
</tr>
<tr>
<td>Measles, Mumps and Rubella (MMR)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Documented 3 doses</td>
</tr>
<tr>
<td>Varicella (chickenpox) (VAR)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Documented 1 dose</td>
</tr>
<tr>
<td>Hepatitis A (Maricopa County only)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Hep A 2</td>
</tr>
</tbody>
</table>
| Summary of vaccines required for 15 months to Pre-kindergarten | 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. ** doses of Hepatitis A are required for children 1-5 years old in Maricopa County only, but are recommended in all other counties.

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

Last revised: October 2018
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.
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.

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>4-6 Years Old Kindergarten or 1st grade</th>
<th>7-10 Years Old</th>
<th>11 Years and Older</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis B (Hep B or HBV)</td>
<td>3 doses</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>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.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poliomyelitis/Polio (IPV or OPV)</td>
<td>4 doses</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>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.</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Polio is not required for students who are 18 years of age or older.</td>
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<td></td>
</tr>
<tr>
<td>Measles, Mumps and Rubella (MMR or MMR-V)</td>
<td>2 doses</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Minimum recommended age for dose #1 is 12 months. A 3rd dose will be required if dose #1 was given more than 4 days before 1st birthday.</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>MMR and Varicella must be given on the same day or at least 28 days apart</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicella (chickenpox) (VAR or MMR-V)</td>
<td>1 dose</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Minimum recommended age for dose #1 is 12 months. 2 doses are required if the 1st dose was given at 13 years of age or older.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>MMR and Varicella must be given on the same day or at least 28 days apart</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diphtheria, Tetanus, and Pertussis</td>
<td>5 doses of DTaP, DTP or DT</td>
<td>4 doses of DTaP, DTP, DT, Tdap or Td</td>
<td>1 dose of Tdap is required</td>
</tr>
<tr>
<td></td>
<td>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.</td>
<td>3 doses acceptable if first dose was given on or after 1st birthday. Tdap given at ages 7-10 will meet the 11-year-old+ Tdap requirement.</td>
<td>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.</td>
</tr>
<tr>
<td>Quadrivalent Meningococcal (MenACWY or MCV4)</td>
<td></td>
<td>1 dose of quadrivalent meningococcal ACWY is required. A dose administered at 10 years of age will meet the requirement.</td>
<td></td>
</tr>
</tbody>
</table>

Please see reverse for additional information and exceptions and conditions to the rules.
GUIDE TO IMMUNIZATIONS REQUIRED FOR ARIZONA SCHOOL ENTRY
GRADERS 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 ACYW 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 ASHS. See reverse side for instructions.

I. IDENTIFICATION INFORMATION

<table>
<thead>
<tr>
<th>Child's Name</th>
<th>Nombre De Niño</th>
<th>Birth Date</th>
<th>Fecha De Nacimiento</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Entry Grade (Circle)</th>
<th>Grado (Marque Con Un Círculo)</th>
<th>Sex</th>
<th>Sexo</th>
</tr>
</thead>
<tbody>
<tr>
<td>K</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

II. IMMUNIZATIONS

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Fecha 1</th>
<th>Fecha 2</th>
<th>Fecha 3</th>
<th>Fecha 4</th>
<th>Fecha 5</th>
<th>Fecha 6</th>
<th>Fecha 7</th>
<th>Fecha 8</th>
<th>Fecha 9</th>
<th>Fecha 10</th>
<th>Fecha 11</th>
<th>Fecha 12</th>
<th>Fecha FU</th>
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<tbody>
<tr>
<td>DTP/DT(T)</td>
<td>Difteria, Tétanos, Pertusis</td>
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<td>Difteria, Tétanos y Tifo Ferina</td>
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<td>DT(T)</td>
<td>Tétanos y Difteria</td>
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<td>(Tipo)</td>
<td>Tétanos, Difteria, acelular Pertusis</td>
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<tr>
<td>IPV/OPV</td>
<td>Pulio Vaccine</td>
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<td>(MMR)</td>
<td>Mesillas, Mumps y Rubéola</td>
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<tr>
<td>Varicela (Chickencox)</td>
<td>Varicela</td>
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<td></td>
<td>Check box if pupil attended childcare/school in AZ with parental recall of chicken pox before 9/1/11</td>
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<td>Meninogococes</td>
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<tr>
<td>Hep A</td>
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<td>Hep B</td>
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<td>HPV</td>
<td>Human Papilloma Virus</td>
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<tr>
<td>[HIB]</td>
<td>Haemophilus Influenzae b</td>
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<tr>
<td>Required for Pre-K program, children age 2 months to age 5 years</td>
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<tr>
<td>Flu</td>
<td>Influenza Haemophilus tipo B</td>
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<tr>
<td>Other</td>
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FOR SCHOOL USE ONLY:

<table>
<thead>
<tr>
<th>School Name</th>
<th>Nombre de Escuela</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact Person</td>
<td>Persona de Contacto</td>
</tr>
<tr>
<td>Phone Number</td>
<td>Número de Teléfono</td>
</tr>
</tbody>
</table>

Initial Enrollment Date in an Arizona School/Preschool:

III. Documentation Presented:

☐ Arizona Lifetime Record
☐ Foreign country (name) __________________________________________
☐ Out-of-State record (name) ________________________________________
☐ ASHS
☐ Provider Record
☐ Other ________________________________________________________________________________________

IV. Status of Requirements:

☐ Currently up-to-date; more doses are due later.
☐ Needs follow-up (see follow-up column).
☐ No immunization record provided.

☐ (reason) ______________________________________________________________________________________

☐ Medical Exemption—Permanent
Date ______/____/____

☐ Laboratory evidence of immunity attached:

☐ Medical Exemption—Temporary until
Date ______/____/____

☐ Personal Beliefs
Date ______/____/____

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

Date ______/____/____

Admitting Official ___________________________________________

Comment Section: ____________________________________________
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(es):
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)

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Trade Name</th>
<th>Abbreviation</th>
<th>Manufacturer</th>
<th>Type / Route</th>
<th>Approved</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adenovirus</td>
<td>Adenovirus Type 4 &amp; Type 7</td>
<td></td>
<td>Barr Labs Inc.</td>
<td>Live Viral / Oral (tabletta)</td>
<td>2011</td>
<td>Approved for military populations 17 through 50 years.</td>
</tr>
<tr>
<td>Anthrax</td>
<td>BioThrax&lt;sup&gt;®&lt;/sup&gt;</td>
<td>AVA</td>
<td>Emergent BioSolutions</td>
<td>Inactivated Bacterial / IM</td>
<td>1970</td>
<td>Age range 18 through 65 years.</td>
</tr>
<tr>
<td>Cholera</td>
<td>Vaxchola&lt;sup&gt;®&lt;/sup&gt;</td>
<td></td>
<td>PaxVax</td>
<td>Live Bacterial / Oral</td>
<td>2016</td>
<td>Age range 18 through 64 years.</td>
</tr>
<tr>
<td>DTaP</td>
<td>Deptacel&lt;sup&gt;®&lt;/sup&gt;</td>
<td>DTaP</td>
<td>sanofi</td>
<td>Inactivated Toxoids and Bacterial / IM</td>
<td>2002</td>
<td>Age range 6 weeks through 6 years.</td>
</tr>
<tr>
<td></td>
<td>Infanrix&lt;sup&gt;®&lt;/sup&gt;</td>
<td>DTaP</td>
<td>GlaxoSmithKline</td>
<td>Inactivated Toxoids and Bacterial / IM</td>
<td>1997</td>
<td>Age range 6 weeks through 6 years.</td>
</tr>
<tr>
<td>DT</td>
<td>Generic</td>
<td>DT</td>
<td>sanofi</td>
<td>Inactivated Bacterial Toxoids / IM</td>
<td>1978</td>
<td>Age range 6 months through 6 years.</td>
</tr>
<tr>
<td>Haemophilus influenza type b (Hib)</td>
<td>ActHIB&lt;sup&gt;®&lt;/sup&gt;</td>
<td>Hib (PRP-T)</td>
<td>sanofi</td>
<td>Inactivated Bacterial / IM</td>
<td>1993</td>
<td>3-dose primary series</td>
</tr>
<tr>
<td></td>
<td>Hiberix&lt;sup&gt;®&lt;/sup&gt;</td>
<td>Hib (PRP-T)</td>
<td>GlaxoSmithKline</td>
<td>Inactivated Bacterial / IM</td>
<td>2009</td>
<td>3-dose primary series</td>
</tr>
<tr>
<td></td>
<td>PedvaxHIB&lt;sup&gt;®&lt;/sup&gt;</td>
<td>Hib (PRP-OMP)</td>
<td>Merck</td>
<td>Inactivated Bacterial / IM</td>
<td>1989</td>
<td>2-dose primary series</td>
</tr>
<tr>
<td>Hepatitis A</td>
<td>Havrix&lt;sup&gt;®&lt;/sup&gt;</td>
<td>HepA</td>
<td>GlaxoSmithKline</td>
<td>Inactivated Viral / IM</td>
<td>1995</td>
<td>Pediatric &amp; adult formulations. Minimum age = 1 year</td>
</tr>
<tr>
<td></td>
<td>Vaqta&lt;sup&gt;®&lt;/sup&gt;</td>
<td>HepA</td>
<td>Merck</td>
<td>Inactivated Viral / IM</td>
<td>1996</td>
<td>Pediatric &amp; adult formulations. Minimum age = 1 year</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>Engerix-B&lt;sup&gt;®&lt;/sup&gt;</td>
<td>HepB</td>
<td>GlaxoSmithKline</td>
<td>Recombinant Viral / IM</td>
<td>1999</td>
<td>Pediatric &amp; adult formulations. Minimum age = birth</td>
</tr>
<tr>
<td></td>
<td>Recombivax HB&lt;sup&gt;®&lt;/sup&gt;</td>
<td>HepB</td>
<td>Merck</td>
<td>Recombinant Viral / IM</td>
<td>1986</td>
<td>Pediatric &amp; adult formulations. Minimum age = birth</td>
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<tr>
<td></td>
<td>Heplisav-B&lt;sup&gt;®&lt;/sup&gt;</td>
<td>HepB</td>
<td>Dynavax Technologies</td>
<td>Recombinant Viral / IM</td>
<td>2017</td>
<td>Adjuvanted</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>Minimum age = 18 years</td>
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<tr>
<td>Herpes Zoster (Shingles)</td>
<td>Zostavax&lt;sup&gt;®&lt;/sup&gt;</td>
<td>ZVL</td>
<td>Merck</td>
<td>Live Attenuated Viral / SC</td>
<td>2006</td>
<td>One dose: Minimum age = 50 years. (ACIP recommends &gt;60 years.)</td>
</tr>
<tr>
<td></td>
<td>Shingrix&lt;sup&gt;®&lt;/sup&gt;</td>
<td>RZV</td>
<td>GlaxoSmithKline</td>
<td>Recombinant Viral / IM</td>
<td>2017</td>
<td>Two doses: Minimum age = 50 years.</td>
</tr>
<tr>
<td>Human Papillomavirus (HPV)</td>
<td>Gardasol&lt;sup&gt;®&lt;/sup&gt; 9</td>
<td>9vHPV</td>
<td>Merck</td>
<td>Inactivated Viral / IM</td>
<td>2014</td>
<td>Approved for males and females 9 through 26 years.</td>
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<tr>
<td>Vaccine</td>
<td>Trade Name</td>
<td>Abbreviation</td>
<td>Manufacturer</td>
<td>Type / Route</td>
<td>Approved</td>
<td>Comments</td>
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<tr>
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<td>Influenza</td>
<td>Afluria®</td>
<td>IV3</td>
<td>Seqirus</td>
<td>Inactivated Viral / IM</td>
<td>2007</td>
<td>Minimum age = 5 years</td>
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<td>IV4</td>
<td></td>
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<td></td>
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<tr>
<td></td>
<td>Fluad®</td>
<td>IV3</td>
<td>Seqirus</td>
<td>Inactivated Viral / IM</td>
<td>2015</td>
<td>Adjuvanted</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>Minimum age = 65 years</td>
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<td></td>
<td>Fluarix®</td>
<td>IV4</td>
<td>GlaxoSmithKline</td>
<td>Inactivated Viral / IM</td>
<td>2012</td>
<td>Minimum age = 6 months</td>
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<tr>
<td></td>
<td>FluBlok®</td>
<td>RIV3</td>
<td>sanofi</td>
<td>Recombinant Viral / IM</td>
<td>2013</td>
<td>Egg Free</td>
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<td></td>
<td></td>
<td>RIV4</td>
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<td>Minimum age = 18 years</td>
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<td>Flucelvax®</td>
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<td>Seqirus</td>
<td>Cell-culture Viral / IM</td>
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<td>Minimum age = 4 years</td>
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<td>Minimum age = 6 months</td>
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<td>FluLaval®</td>
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<td>GlaxoSmithKline</td>
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<td>2013</td>
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<td></td>
<td>FluMist®</td>
<td>LAIV4</td>
<td>Medimmune</td>
<td>Live Attenuated Viral / Intranasal (spray)</td>
<td>2003</td>
<td>Age range 2 through 49 years</td>
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<td>High-Dose</td>
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<td>Japanese</td>
<td>Ixiaro®</td>
<td>JE</td>
<td>Valneva</td>
<td>Inactivated Viral / IM</td>
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<td>Minimum age = 2 months</td>
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<td>Measles, Mumps,</td>
<td>M-M-R® II</td>
<td>MMR</td>
<td>Merck</td>
<td>Live Attenuated Viral / SC</td>
<td>1978</td>
<td>Minimum age = 12 months</td>
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<tr>
<td>Rubella</td>
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<td></td>
<td>(First MMR – 1971)</td>
<td>Minimum age = 12 months</td>
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<tr>
<td>Meningocccal</td>
<td>Menactra®</td>
<td>MCV4</td>
<td>sanofi</td>
<td>Inactivated Bacterial / IM</td>
<td>2005</td>
<td>Age range 9 months through 55 years</td>
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<td>MenACWY</td>
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<td>Menveo®</td>
<td>MCV4</td>
<td>GlaxoSmithKline</td>
<td>Inactivated Bacterial / IM</td>
<td>2010</td>
<td>Age range 2 months through 55 years</td>
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<td>MenACWY</td>
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<td>Trumenba®</td>
<td>MenB</td>
<td>Pfizer</td>
<td>Recombinant Bacterial / IM</td>
<td>2014</td>
<td>Age range 10 through 25 years</td>
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<td>Bexsero®</td>
<td>MenB</td>
<td>GlaxoSmithKline</td>
<td>Recombinant Bacterial / IM</td>
<td>2015</td>
<td>Age range 10 through 25 years</td>
</tr>
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<tr>
<td>Vaccine</td>
<td>Trade Name</td>
<td>Abbreviation</td>
<td>Manufacturer</td>
<td>Type / Route</td>
<td>Approved</td>
<td>Comments</td>
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<td>Pneumococcal</td>
<td>Pneumovax&lt;sup&gt;®&lt;/sup&gt; 23</td>
<td>PPSV23</td>
<td>Merck</td>
<td>Inactivated Bacterial / SC or IM</td>
<td>1983</td>
<td>Minimum age = 2 years</td>
</tr>
<tr>
<td></td>
<td>Prevnar 13&lt;sup&gt;®&lt;/sup&gt;</td>
<td>PCV13</td>
<td>Pfizer</td>
<td>Inactivated Bacterial / IM</td>
<td>2010</td>
<td>Minimum age = 6 weeks</td>
</tr>
<tr>
<td>Polio</td>
<td>Ipol&lt;sup&gt;®&lt;/sup&gt;</td>
<td>IPV</td>
<td>sanofi</td>
<td>Inactivated Viral / SC or IM</td>
<td>1990</td>
<td>Minimum age = 6 weeks</td>
</tr>
<tr>
<td>Rabies</td>
<td>Imovax&lt;sup&gt;®&lt;/sup&gt; Rabies</td>
<td></td>
<td>sanofi</td>
<td>Inactivated Viral / IM</td>
<td>1990</td>
<td>All ages</td>
</tr>
<tr>
<td></td>
<td>RabAvert&lt;sup&gt;®&lt;/sup&gt;</td>
<td></td>
<td>GlaxoSmithKline</td>
<td>Inactivated Viral / IM</td>
<td>1997</td>
<td>All ages</td>
</tr>
<tr>
<td>Rotavirus</td>
<td>RotaTeq&lt;sup&gt;®&lt;/sup&gt;</td>
<td>RV5</td>
<td>Merck</td>
<td>Live Viral / Oral (liquid)</td>
<td>2006</td>
<td>3-dose series 1&lt;sup&gt;st&lt;/sup&gt; dose 6 through 14 weeks</td>
</tr>
<tr>
<td></td>
<td>Rotarix&lt;sup&gt;®&lt;/sup&gt;</td>
<td>RV1</td>
<td>GlaxoSmithKline</td>
<td>Live Viral / Oral (liquid)</td>
<td>2008</td>
<td>2-dose series 1&lt;sup&gt;st&lt;/sup&gt; dose 6 through 14 weeks</td>
</tr>
<tr>
<td>Tetanus, (reduced)</td>
<td>Tenivac&lt;sup&gt;®&lt;/sup&gt;</td>
<td>Td</td>
<td>sanofi</td>
<td>Inactivated Bacterial / IM</td>
<td>2003</td>
<td>Minimum age = 7 years</td>
</tr>
<tr>
<td>Diphtheria</td>
<td>(Generic)</td>
<td>Td</td>
<td>Massachusetts Labs</td>
<td>Inactivated Bacterial / IM</td>
<td>1987</td>
<td>Minimum age = 7 years</td>
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<tr>
<td>Tetanus, (reduced)</td>
<td>Boostrix&lt;sup&gt;®&lt;/sup&gt;</td>
<td>Tdap</td>
<td>GlaxoSmithKline</td>
<td>Inactivated Bacterial / IM</td>
<td>2005</td>
<td>Minimum age = 10 years</td>
</tr>
<tr>
<td>Diphtheria, (reduced)</td>
<td>Adacel&lt;sup&gt;®&lt;/sup&gt;</td>
<td>Tdap</td>
<td>sanofi</td>
<td>Inactivated Bacterial / IM</td>
<td>2005</td>
<td>Age range 10 through 64 years</td>
</tr>
<tr>
<td>Pertussis</td>
<td>Typhim V&lt;sup&gt;®&lt;/sup&gt;</td>
<td></td>
<td>sanofi</td>
<td>Inactivated Bacterial / IM</td>
<td>1994</td>
<td>Minimum age = 2 years</td>
</tr>
<tr>
<td>Typhoid</td>
<td>Vivotif&lt;sup&gt;®&lt;/sup&gt;</td>
<td></td>
<td>PaxVax</td>
<td>Live Attenuated Bacterial / Oral (4 capsules)</td>
<td>1999</td>
<td>Minimum age = 6 years</td>
</tr>
<tr>
<td>Varicella</td>
<td>Varivax&lt;sup&gt;®&lt;/sup&gt;</td>
<td>VAR</td>
<td>Merck</td>
<td>Live Attenuated Viral / SC</td>
<td>1995</td>
<td>Minimum age = 12 months</td>
</tr>
<tr>
<td>Vaccinia (Smallpox)</td>
<td>ACAM2000&lt;sup&gt;®&lt;/sup&gt;</td>
<td></td>
<td>sanofi</td>
<td>Live Attenuated Viral / Percutaneous</td>
<td>2007</td>
<td>All ages</td>
</tr>
<tr>
<td>Yellow Fever</td>
<td>YF-Vax&lt;sup&gt;®&lt;/sup&gt;</td>
<td>YF</td>
<td>sanofi</td>
<td>Live Attenuated Viral / SC</td>
<td>1978</td>
<td>Minimum age = 9 months</td>
</tr>
</tbody>
</table>
# U.S. Vaccines: Table 2

(Combination Vaccines)

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

## 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.
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.

**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__________

**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__________

**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__________

**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__________

**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__________

**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__________

**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__________

**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)__________________


F - 5 -1
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 ______________


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.

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: __________

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: __________

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: __________

Poliomyelitis (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: __________

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: __________

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: __________

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: __________

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: __________

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 health department and Arizona Department of Health Services (www.azdhs.gov/phs/immunize/).
- 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).

<table>
<thead>
<tr>
<th>Required Vaccine</th>
<th>Dose Missing</th>
</tr>
</thead>
<tbody>
<tr>
<td>DTaP/DTP/DT (Diphtheria, Tetanus, Pertussis)</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>Hib (Haemophilus influenza type b)</td>
<td>1 2 3 4*</td>
</tr>
<tr>
<td>IPV (Poliomyelitis)</td>
<td>1 2 3</td>
</tr>
<tr>
<td>MMR (Measles, Mumps, Rubella)</td>
<td>1</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>1 2 3 4*</td>
</tr>
<tr>
<td>Varicella (Chickenpox)</td>
<td>1</td>
</tr>
<tr>
<td>Hepatitis A*</td>
<td>1 2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CDC Recommended Vaccine**</th>
<th>Dose Missing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis A*</td>
<td>1 2</td>
</tr>
<tr>
<td>Rotavirus</td>
<td>1 2 3</td>
</tr>
<tr>
<td>Seasonal Influenza (Flu)</td>
<td>1</td>
</tr>
<tr>
<td>Pneumococcal (PCV13)</td>
<td>1 2 3 4</td>
</tr>
</tbody>
</table>

* 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

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).

<table>
<thead>
<tr>
<th>School Required Vaccine</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>DTaP/DTP/DT (Diphtheria,Tetanus, Pertussis)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Td (Tetanus, Diphtheria)</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Tdap (Tetanus, Diphtheria, Pertussis)</td>
<td></td>
<td></td>
<td>3*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IPV (Polio)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4*</td>
<td></td>
</tr>
<tr>
<td>MMR (Measles, Mumps, Rubella)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4*</td>
<td></td>
</tr>
<tr>
<td>Hepatitis B</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4*</td>
<td></td>
</tr>
<tr>
<td>Varicella (Chickenpox)</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meningococcal (MCV4/quadrivalent)</td>
<td></td>
<td>2*</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CDC Recommended Vaccine</strong></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

- * 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.

ADHS-Arizona Immunization Program Office: (602)-364-3630 F - 6 - 2 Revised Sept. 2018
ASIIS Enrollment Application

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:  
☐ 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.
<table>
<thead>
<tr>
<th>Facility #1</th>
<th>Facility #2</th>
<th>Facility #3</th>
<th>Facility #4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
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</tr>
<tr>
<td>Physical Address:</td>
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<td>Facility Contact:</td>
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<td>E-mail address:</td>
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</table>
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.

<table>
<thead>
<tr>
<th>Name</th>
<th>Email Address</th>
<th>Privilege</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>○View ○Edit</td>
</tr>
<tr>
<td></td>
<td></td>
<td>○View ○Edit</td>
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<td></td>
<td></td>
<td>○View ○Edit</td>
</tr>
</tbody>
</table>

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.
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: ___/___/____ (Date)  MUMPS: ___/___/____ (Date)  RUBELLA: ___/___/____ (Date)
Or
MMR: #1 ___/___/____ (Date)  #2 ___/___/____ (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.

<table>
<thead>
<tr>
<th>Test</th>
<th>Grade</th>
<th>Pre-K</th>
<th>K</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Height/Weight/BMI</td>
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<td>R</td>
<td>R</td>
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<td>R</td>
<td>R</td>
<td>R</td>
<td>R</td>
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<tr>
<td>Far Vision¹</td>
<td></td>
<td>R</td>
<td>R</td>
<td>R</td>
<td>R</td>
<td>R</td>
<td>R</td>
<td>R</td>
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<tr>
<td>Strabismus</td>
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<td>R</td>
<td>R</td>
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<td>R</td>
<td>R</td>
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<tr>
<td>Color Vision²</td>
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<td>R</td>
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<tr>
<td>Hearing³</td>
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<td>M</td>
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</tr>
<tr>
<td>Scoliosis⁴</td>
<td></td>
<td>R</td>
<td>R</td>
<td>R</td>
<td>R</td>
<td>R</td>
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<td>Blood Pressure</td>
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<td>R</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Test</th>
<th>Grade</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Height/Weight/BMI</td>
<td></td>
<td>R</td>
<td>R</td>
<td>R</td>
<td>R</td>
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<tr>
<td>Far Vision¹</td>
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<td>R</td>
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<tr>
<td>Hearing³</td>
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<td>M</td>
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<tr>
<td>Scoliosis⁴</td>
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<td>R</td>
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<td></td>
</tr>
<tr>
<td>Blood Pressure⁵</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>R</td>
</tr>
</tbody>
</table>

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/ocshcn/index.php/hearing-screening

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

I. School Information

<table>
<thead>
<tr>
<th>School's Complete Name:</th>
<th>County Type District School (CTDS)- 9 DIGITS (If applicable, no spaces and no dashes):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>[Public] Public □ Private □ Charter □ Preschool □ Kindergarten □ Other (Please specify)</td>
</tr>
<tr>
<td>District Name/Charter Holder Name:</td>
<td>School's Phone Number:</td>
</tr>
<tr>
<td>School's (not district) Address:</td>
<td>City:</td>
</tr>
<tr>
<td>Zip Code:</td>
<td>Fax Number:</td>
</tr>
</tbody>
</table>

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)

- [□] Screener(s)
- [□] Volunteer(s)
- [□] Audiologist (Please include name and license number)

Screeners: (Names)

<table>
<thead>
<tr>
<th>Screener 1</th>
<th>Screener 2</th>
<th>Screener 3</th>
<th>Screener 4</th>
<th>Screener 5</th>
<th>Screener 6</th>
<th>Screener 7</th>
<th>Screener 8</th>
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<tbody>
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</tbody>
</table>

"Hearing screener(s)" certificates must be valid at time of screening and must reflect training on equipment used.

Does your school have an audiologist?  Yes □ No □

(Audiologist—please include name and license number)

Does your school have a licensed school nurse?  Yes □ No □

Dedicated (only works at your school). Please include the name

Shared (school nurse is shared throughout the district). Please include the name
III. Reporter Information

<table>
<thead>
<tr>
<th>Report Completed by: (Name)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Complete by: (Title)</td>
</tr>
<tr>
<td>Administrative Assistant</td>
</tr>
<tr>
<td>Audiologist</td>
</tr>
<tr>
<td>Director</td>
</tr>
<tr>
<td>Health Aide</td>
</tr>
<tr>
<td>Hearing Screener</td>
</tr>
<tr>
<td>Nurse Assistant</td>
</tr>
<tr>
<td>School's Nurse</td>
</tr>
<tr>
<td>Other (Please specify)</td>
</tr>
</tbody>
</table>

Report completed by: (email address)

Report completed by: (date) (mm/dd/yyyy)

IV. Equipment Information

<table>
<thead>
<tr>
<th>Used ADHS Equipment:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes (Only ADHS)</td>
</tr>
<tr>
<td>No (Used own equipment)</td>
</tr>
<tr>
<td>Both (ADHS and own equipment)</td>
</tr>
</tbody>
</table>

Equipment Calibration Date(s): (Only if used own equipment) (mm/dd/yyyy)

<table>
<thead>
<tr>
<th>Type of equipment used (only fill out the information that is applicable for your school)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audiometer</td>
</tr>
<tr>
<td>Tympanometer</td>
</tr>
<tr>
<td>OAE</td>
</tr>
<tr>
<td>Other (Please specify)</td>
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</tbody>
</table>

H - 2
V. Hearing Information by Grade (only fill out the information that is applicable for your school)

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

<table>
<thead>
<tr>
<th>Date</th>
<th>Age</th>
<th>Weight</th>
<th>Stature</th>
<th>BMI*</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

*To Calculate BMI: Weight (kg) ÷ Stature (cm) × Stature (cm) × 10,000  
or Weight (lb) ÷ Stature (in) × Stature (in) × 703

Published May 20, 2000 (modified 10/19/00).  
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
### 2 to 20 years: Girls

Body mass index-for-age percentiles

<table>
<thead>
<tr>
<th>Date</th>
<th>Age</th>
<th>Weight</th>
<th>Stature</th>
<th>BMI*</th>
<th>Comments</th>
</tr>
</thead>
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</tbody>
</table>

*BMI* = Weight (kg) ÷ Stature (cm)^2

\[ \text{BMI} = \frac{\text{Weight (kg)}}{\text{Stature (cm)}^2} \]

*To Calculate BMI:
- Weight (kg) x 703
- Stature (in.) x 10,000
- Weight (lb) x 703
- Stature (in.) x 10,000

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
## Blood Pressure Referral Levels for Boys by Age and Height Percentile

<table>
<thead>
<tr>
<th>Age (Year)</th>
<th>BP Percentile</th>
<th>Systolic BP (mmHg)</th>
<th></th>
<th>Diastolic BP (mmHg)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>5th 10th 25th 50th 75th 90th 95th</td>
<td></td>
<td>5th 10th 25th 50th 75th 90th 95th</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>95th</td>
<td>108 109 110 112 114 115 116</td>
<td>69 70 71 72 73 74 74</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>99th</td>
<td>115 116 118 120 121 123 123</td>
<td>77 78 79 80 81 81 82</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>95th</td>
<td>109 110 112 114 115 117 117</td>
<td>72 72 73 74 75 76 76</td>
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<td></td>
<td>99th</td>
<td>115 117 119 121 123 124 125</td>
<td>80 80 81 82 83 84 84</td>
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<tr>
<td>7</td>
<td>95th</td>
<td>110 111 113 115 117 118 119</td>
<td>74 74 75 76 77 78 78</td>
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### Blood Pressure Referral Levels for Girls by Age and Height Percentile

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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 ________________

H - 5
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:

I. Student Standing, Facing Examiner
   1. Posture-Head and neck not centered. 1.____  _____  _____
   2. Uneven shoulders. 2.____  _____  _____
   3. Uneven hips, accentuated waist crease on one side. 3.____  _____  _____
   4. Unequal arm-body space. 4.____  _____  _____
   5. Unequal arm length--one arm shorter than other. 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. 7.____  _____  _____
   8. Uneven scapula. 8.____  _____  _____
   9. Uneven hip, accentuated waist crease on one side. 9.____  _____  _____
   10. Unequal arm-body space. 10.____  _____  _____
   11. Visible lateral curvature of spine. 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). 13.____  _____  _____

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 Scoliomter.
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: ________________________________________________________________

________________________________________

I - 1
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:

<table>
<thead>
<tr>
<th>Date of Screening</th>
<th>Blood Pressure Reading</th>
<th>Arm Used</th>
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<tr>
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<td>3. _____________</td>
<td>_______________</td>
<td>Rt. ___  Lt. ___</td>
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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 Pediatrician Orthopedist
SIGNED ____________________________________________ M.D.
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)

I - 5
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 Pediatrics (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 reinfection 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 ⅛ 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)
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.
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 make the activity 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.

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.

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

EPA
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.

LightenUp!  
Pack It Light. Wear It Right

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Cold or Flu Symptoms

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°F 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:

<table>
<thead>
<tr>
<th>SYMPTOM</th>
<th>COLD</th>
<th>FLU*</th>
</tr>
</thead>
<tbody>
<tr>
<td>FEVER</td>
<td>Fever is uncommon with a cold.</td>
<td>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.</td>
</tr>
<tr>
<td>ACHES</td>
<td>Slight body aches may be present with a cold.</td>
<td>Severe aches and pains are common with the flu.</td>
</tr>
<tr>
<td>CHILLS</td>
<td>Chills are uncommon with a cold.</td>
<td>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.</td>
</tr>
<tr>
<td>TIREDNESS</td>
<td>Tiredness is mild with a cold.</td>
<td>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.</td>
</tr>
<tr>
<td>SUDDEN SYMPTOMS</td>
<td>Cold symptoms are gradual and develop over a few days.</td>
<td>The flu has a rapid onset within 3-6 hours. The flu hits hard and includes sudden symptoms like high fever, aches, and pains.</td>
</tr>
<tr>
<td>COUGHING</td>
<td>A hacking, productive (with mucus) cough is often present with a cold.</td>
<td>A nonproductive cough that does not produce mucus is usually present with the flu. Dry cough is present in 80% of flu cases.</td>
</tr>
<tr>
<td>SNEEZING</td>
<td>Sneezing is common with a cold.</td>
<td>Sneezing is not commonly present with the flu.</td>
</tr>
<tr>
<td>STUFFY NOSE</td>
<td>A stuffy nose usually accompanies a cold and typically resolves spontaneously within a week.</td>
<td>Stuffy nose is not commonly present with the flu.</td>
</tr>
<tr>
<td>SORE THROAT</td>
<td>Sore throat is common with a cold.</td>
<td>A sore throat is not commonly present with the flu.</td>
</tr>
<tr>
<td>CHEST DISCOMFORT</td>
<td>Chest discomfort is mild to moderate with a cold.</td>
<td>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.</td>
</tr>
<tr>
<td>HEADACHE</td>
<td>A headache is fairly uncommon with a cold.</td>
<td>A headache is very common with the flu. It is present in 80% of flu cases.</td>
</tr>
</tbody>
</table>

* 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.
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
School Health Services

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.
Sore Throat

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 saltwater 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, it 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.
Stomach Ache

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

The nurse/health aide implemented the following interventions:

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

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: Bananas, Rice, Applesauce, and dry Toast, 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.
Strain/Sprain

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
SCHOOL HEALTH SERVICES

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.
Urinary Tract Infection

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.
DIOCESE OF TUCSON CATHOLIC SCHOOLS
SCHOOL HEALTH SERVICES

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.
# EYE INJURY

## REPORT OF CUT OR BLOW TO EYE

### ASSESS SIGNS & SYMPTOMS

<table>
<thead>
<tr>
<th>Eye Injured:</th>
<th>BOTH</th>
<th>RIGHT</th>
<th>LEFT</th>
</tr>
</thead>
<tbody>
<tr>
<td>WITHOUT TOUCHING, INSPECT EYE.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appears cut or ruptured?</td>
<td>YES</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>Shape of eyeball &quot;squashed&quot; or abnormal?</td>
<td>YES</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>Iris cloudy or bloody?</td>
<td>YES</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>Blood over sclera?</td>
<td>YES</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>Pupil abnormal shape?</td>
<td>YES</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>Sharp object imbedded in eye?</td>
<td>YES</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>Eyelid cut or lacerated?</td>
<td>YES</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>Unable to open eye (after calm)?</td>
<td>YES</td>
<td>NO</td>
<td></td>
</tr>
</tbody>
</table>

### INTERVENE

<table>
<thead>
<tr>
<th>Eye Splashed:</th>
<th>BOTH</th>
<th>RIGHT</th>
<th>LEFT</th>
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<tbody>
<tr>
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## REPORT OF CHEMICAL SPLASHED IN EYE

### INTERVENE

- Flush from nose outward with lukewarm tap water by placing face under tap with eye open or pouring from container.
- Instruct student to move eye and open & close lids repetently to aid flushing.
- Pull eyelashes forward to allow water to flow under lid.
- Determine chemical involved.
- Consult AZ Poison Control Center (1-800-222-1222.)
- Continue flushing at least 10 minutes.

## ASSESS

### BEFORE INJURY

- Eye does not move well in all directions?
  - YES
  - NO
- Movement of eye causes pain?
  - YES
  - NO
- Visual change (either reported by student or detected by screening)?
  - YES
  - NO

### AFTER INJURY

- Have lie quietly on back.
- Never attempt to remove imbedded object.
- Protect injured eye with shield or disposable cup inverted & taped securely. *Apply no pressure to eyeball.*
- 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.

## CONTINUE ASSESSMENT

### BEFORE INJURY

- Eye struck by fast moving blunt object (fist or ball), projectile (metal/stone chip), vegetative matter, or sharp object?
  - YES
  - NO

### AFTER INJURY

- Have lie quietly on back.
- Protect injured eye with shield or disposable cup inverted & taped securely. *Apply no pressure to eyeball.*
- 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.

## NO TO ANY

- Call or write parents-Time:
- Send back to class.
- Recheck later in day or next day.

## YES TO ANY

- Call Nurse-Time:
- Call parents-Time:
- Refer to doctor.
- 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.
FRACTURES, DISLOCATIONS, STRAINS, SPRAINS, CONTUSIONS
Record assessments & interventions by circling YES, NO, & intervention done, plus filling in blanks.

ASSESS SIGNS & SYMPTOMS

<table>
<thead>
<tr>
<th>Time:</th>
<th>Localized pain &amp; tenderness?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pulse:</td>
<td>YES  NO</td>
</tr>
<tr>
<td>BP:</td>
<td>Where?</td>
</tr>
<tr>
<td>Swelling?</td>
<td>YES  NO</td>
</tr>
<tr>
<td>Discoloration?</td>
<td>YES  NO</td>
</tr>
<tr>
<td>Guarding; limitation of motion/function?</td>
<td>YES  NO</td>
</tr>
</tbody>
</table>

IF YES TO ANY ABOVE
CONTINUE ASSESSMENT

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

Injury caused by blow to muscle?
- YES
- NO

NO
STRAIN

YES
CONTUSION

NO
SPRAIN

YES TO ANY
MAY BE Fx/DISLOCATION

Deep laceration & or exposed bone?  YES  NO

INTERVENE

- 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.

NO
INTERVENE

- 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.

YES
INTERVENE

- 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.
When, where, how injury incurred, plus complaints, Re: pain & function:

Time of Incident: Arrival in Health Office: Departure:
Signature: Title:

**HEAD INJURY**

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

<table>
<thead>
<tr>
<th>GLASGOW COMA SCALE</th>
<th>Initial</th>
<th>5 Min</th>
<th>30 Min</th>
<th>60 Min</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. BEST EYE OPENING</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spontaneous</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To Voice</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To Pain</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Swollen Shut</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. BEST VERBAL RESPONSE*</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oriented</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Confused</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inappropriate Words</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Incomprehensible Sounds</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. BEST MOTOR RESPONSE</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obey Commands</td>
<td>6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Localizes Pain</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Withdraws to Pain</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Flexes to Pain</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extends to Pain</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GLASGOW COMA TOTAL</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**PUPILS**

<table>
<thead>
<tr>
<th>RIGHT</th>
<th>Initial</th>
<th>5 Min</th>
<th>30 Min</th>
<th>60 Min</th>
</tr>
</thead>
<tbody>
<tr>
<td>SIZE</td>
<td>RESPONSE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LEFT</td>
<td>RESPONSE</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*PRE VERBAL:
5 Smiles, coos, cries appropriately
4 Cries
3 Inappropriate crying and/or screaming
2 Grunts
1 None

---

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:**

---

**YES TO ANY OR GCS BELOW 15**

**INTERVENE**

- 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 Ds & Rx info.

---

**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

---

**IF YES**

**INTERVENE**

- Do NOT remove embedded 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 Ds & Rx info.

---

**WHETHER YES OR NO**

**INTERVENE**

- **Apply ice.**
- **Observe 20 - 30 minutes.**

---

**BLEEDING**

**YES NO**

**SWELLING**

**YES NO**

---

**K - 3**
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.

• Call parents- Time: __________
  • Send head injury note home.
  • Send back to class.
  • Recheck later in day.

• 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.
SHOCK

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

### ASSESS SIGNS & SYMPTOMS

<table>
<thead>
<tr>
<th></th>
<th>TIME</th>
<th>RESP</th>
<th>PULSE</th>
<th>BP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rapid Breathing?</td>
<td>YES</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rapid/weak pulse?</td>
<td>YES</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decreased BP?</td>
<td>YES</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Restless or irritable?</td>
<td>YES</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pale/bluish, cool, moist skin?</td>
<td>YES</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Slow capillary filling time?</td>
<td>YES</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heavy sweating?</td>
<td>YES</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dilated pupils?</td>
<td>YES</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dull, sunken look to eyes?</td>
<td>YES</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Excessive thirst?</td>
<td>YES</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nausea/vomiting?</td>
<td>YES</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drowsiness/loss of consciousness?</td>
<td>YES</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### NO, IS NOT SHOCK

**INTERVENE TO PREVENT**

- Have lie down flat.
- Preserve body heat.

#### YES, IS SHOCK

**INTERVENE**

- Elevate legs 8-12" if no spinal injury.
- Preserve body heat with blankets under & over.
- Do NOT give anything to eat or drink.
- Call 911 - Time: ____________
- Call nurse - Time: ____________
- Call parents - Time: ____________
- Send documentation with student for doctor.
- Follow up for Dx & Rx info.
## SUSPECTED SUBSTANCE ABUSE - PHYSICAL ASSESSMENT CHECKLIST

### SUBJECTIVE

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>How do you feel?</td>
<td></td>
</tr>
<tr>
<td>Are you ill?</td>
<td></td>
</tr>
<tr>
<td>Are you diabetic?</td>
<td></td>
</tr>
<tr>
<td>Do you take insulin?</td>
<td></td>
</tr>
<tr>
<td>Do you have epilepsy?</td>
<td></td>
</tr>
<tr>
<td>Have you ever had a head injury?</td>
<td></td>
</tr>
<tr>
<td>When did you last eat?</td>
<td></td>
</tr>
<tr>
<td>What did you eat?</td>
<td></td>
</tr>
<tr>
<td>How much sleep in past 24 hours?</td>
<td></td>
</tr>
<tr>
<td>When did you wake up?</td>
<td></td>
</tr>
<tr>
<td>Are you on any medication?</td>
<td></td>
</tr>
<tr>
<td>Name of medication</td>
<td></td>
</tr>
<tr>
<td>Have you taken any drugs?</td>
<td></td>
</tr>
<tr>
<td>What kind?</td>
<td></td>
</tr>
<tr>
<td>If you took a drug test today, would you pass it?</td>
<td></td>
</tr>
<tr>
<td>Do you know why you have been referred to the health office?</td>
<td></td>
</tr>
</tbody>
</table>

### OBJECTIVE

<table>
<thead>
<tr>
<th>Measurement</th>
<th>Normal Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pulse</td>
<td>60-90</td>
</tr>
<tr>
<td>Blood Pressure</td>
<td>120-140 / 70-90</td>
</tr>
<tr>
<td>Respiration</td>
<td>12 - 15</td>
</tr>
<tr>
<td>Temperature</td>
<td>98.6°F ± 1°F</td>
</tr>
<tr>
<td>Pupils: React to Light</td>
<td></td>
</tr>
<tr>
<td>Pupil Size</td>
<td>3.0 - 6.5 (millimeters)</td>
</tr>
<tr>
<td>Conjunctiva</td>
<td></td>
</tr>
<tr>
<td>Odor: (Circle all that apply.)</td>
<td></td>
</tr>
<tr>
<td>anxious</td>
<td></td>
</tr>
<tr>
<td>disoriented</td>
<td></td>
</tr>
<tr>
<td>sluggish</td>
<td></td>
</tr>
<tr>
<td>cooperative</td>
<td></td>
</tr>
<tr>
<td>euphoric</td>
<td></td>
</tr>
<tr>
<td>irritable</td>
<td></td>
</tr>
<tr>
<td>combative</td>
<td></td>
</tr>
<tr>
<td>excited</td>
<td></td>
</tr>
<tr>
<td>restless</td>
<td></td>
</tr>
<tr>
<td>stuporous</td>
<td></td>
</tr>
<tr>
<td>confused</td>
<td></td>
</tr>
<tr>
<td>alert</td>
<td></td>
</tr>
<tr>
<td>oriented</td>
<td></td>
</tr>
<tr>
<td>S.A.F.E. Substance Abuse Free Environment Substance Abuse Identification Programs</td>
<td></td>
</tr>
</tbody>
</table>

### Internal Clock Estimation:

- Body Tremors: __________
- Eyelid Tremors: __________
- HGN: __________
  - (Horizontal gaze nystagmus)
- VGN: __________
  - (Vertical gaze nystagmus)

### Modified Romberg:

- Sway: __________

---

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

Observer’s signature and title: __________

---

K - 5
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: _______________________

L - 1
PART A

SCHOOL/CHURCH STATEMENT

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

NAME OF INJURED PERSON: FIRST MI LAST

NAME OF SCHOOL/CHURCH:

ADDRESS OF SCHOOL/CHURCH:

DATE OF INJURY:

TIME OF INJURY:

INJURY OCCURRED

PRACTICE

GAME

RE

CLASSROOM

TRAVEL

TYPE OF SPORT

DETAILS ON HOW THE INJURY OCCURRED, PLEASE BE SPECIFIC:

WAS STUDENT PARTICIPATING IN SPORT NOT SCHOOL-RELATED?

WHAT PART OF THE BODY WAS INJURED?

HAS THE STUDENT SUFFERED FROM SAME OR SIMILAR CONDITION BEFORE?

INDICATE IF INJURY WAS RECEIVED DURING PARTICIPATION IN THE FOLLOWING ACTIVITIES. PLEASE CHECK THE APPROPRIATE BOX:

NAME OF SUPERVISOR:

DATE SCHOOL/CHURCH WAS NOTIFIED OF ACCIDENT:

WAS HE/SHE A WITNESS TO THE ACCIDENT?

NAME OF SCHOOL/CHURCH OFFICIAL:

SIGNATURE OF SCHOOL/CHURCH OFFICIAL:

DATE SIGNED:

SCHOOL/CHURCH TELEPHONE NO.:

NAME, ADDRESS AND PHONE # OF INSURED’S FAMILY PHYSICIAN:

PART B

PARENT OR GUARDIAN STATEMENT

RELATIONSHIP TO INJURED:

IS THIS DEPENDENT COVERED BY OTHER HEALTH AND/OR ACCIDENT INSURANCE PLAN?

NAME OF FATHER OR MALE GUARDIAN:

S.S. # OF FATHER OR MALE GUARDIAN:

HOME TELEPHONE NO.:

ADDRESS:

NAME OF EMPLOYER:

WORK TELEPHONE AND EXTENSION NO.:

ADDRESS OF EMPLOYER:

NAME OF OTHER HEALTH AND/OR ACCIDENT INSURANCE COMPANY THROUGH FATHER OR MALE GUARDIAN:

POLICY NUMBER:

TELEPHONE NO.:

ADDRESS OF INSURANCE COMPANY:

NAME OF MOTHER OR FEMALE GUARDIAN:

S.S. # OF MOTHER OR FEMALE GUARDIAN:

HOME TELEPHONE NO.:

ADDRESS:

NAME OF EMPLOYER:

WORK TELEPHONE AND EXTENSION NO.:

ADDRESS OF EMPLOYER:

NAME OF OTHER HEALTH AND/OR ACCIDENT INSURANCE COMPANY THROUGH MOTHER OR FEMALE GUARDIAN:

POLICY NUMBER:

TELEPHONE NO.:

ADDRESS OF INSURANCE COMPANY:

PARENT OR GUARDIAN SIGNATURE:

I understand that any person who knowingly and with intent to defraud any insurance company or other person fills 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 & Toteay & Co., Inc., and addresses to those so notified, any information regarding any injury, illness, policy coverage, medical history, consultation, prescription or treatment, and copies of all hospital or medical records and incurred costs, and to pay benefits based upon this information. A photostatic copy of this authorization shall be considered as valid and effective as the original.

AUTHORIZED TO PAY BENEFITS TO PROVIDER, I authorize payment of Medical payments to Physician or Supplier for Services on the attached.

SIGNATURE OF PARENT OR GUARDIAN

DATE

1110 REV. 04/02 DIOCESE AZ-CA

L - 2
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.
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: ________________________

M - 1
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 _______ Other __________________
4) List insulin(s) or medication(s) ____________________________
5) Date of diabetes diagnosis _________________________________
6) Student’s Pediatric Endocrinologist/Pediatrician and contact numbers:
   Name ____________________________ Phone #s ____________________________ Phone # __________
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 (_______) ___________ _

1-800-LUNGUSA | LUNG.org

Date _____/_____/_______
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

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

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 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): ___________________________

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.

PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE: ___________________________

DATE: ___________________________

PHYSICIAN/HCP AUTHORIZATION SIGNATURE: ___________________________

DATE: ___________________________

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2018
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: _______
PLAN DE ATENCIÓN DE EMERGENCIAS DE Alergias ALIMENTARIAS Y ANAFLAXIA

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 reativo 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 SEGUNDO que se ha ingerido el alérgeno, administre epinefrina de inmediato aunque no se observe ningún síntoma.

ANTE CUALQUIERA DE LOS SIGUIENTES: SÍNTOMAS GRAVES

PULMÓN
Falla de aire, sibilancia, mucha tos

CORAZÓN
Tecoluzada o palida, 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

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:

1. Se pueden administrar antihistamínicos, con prescripción médica.

2. Quédese junto a la persona; comuníquese con los contactos de emergencia.

3. Observe atentamente los posibles cambios. Si los síntomas empeoran, administre epinefrina.

1. INYECTE EPINEFRINA DE INMEDIATO

2. Llame al 911. Avise al operador telefónico que el paciente tiene anafilaxia y puede necesitar epinefrina cuando llegue el equipo de emergencia.

Considerar 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.

-Lléve 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).

MÉDICAMENTOS/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): ___________________________
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 masajea 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 ADRENAClick®), 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 masajea 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: ____________________________________________ TELEFÓNICO: ____________________________
MÉDICO: ____________________________ TELEFÓNICO: ____________________________
PÁRE O TUTOR: ____________________________ TELEFÓNICO: ____________________________

OTROS CONTACTOS DE EMERGENCIA
NUMERO RELACIÓN: ____________________________________________
TELEFÓNICO: ____________________________________________
NOMBRE RELACIÓN: ____________________________________________
TELEFÓNICO: ____________________________________________

FORMULARIO SUMINISTRADO POR CORTESÍA DE FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2018
# Seizure Action Plan

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

<table>
<thead>
<tr>
<th>Student's Name</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent/Guardian</td>
<td>Phone</td>
</tr>
<tr>
<td>Other Emergency Contact</td>
<td>Phone</td>
</tr>
<tr>
<td>Treating Physician</td>
<td>Phone</td>
</tr>
</tbody>
</table>

## Significant Medical History

### Seizure Information

<table>
<thead>
<tr>
<th>Seizure Type</th>
<th>Length</th>
<th>Frequency</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

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

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

### Emergency Response

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

Seizure Emergency Protocol

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

### Treatment Protocol During School Hours (Include daily and emergency medications)

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</tbody>
</table>

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 ____________
**Communicable Disease Report for Healthcare Providers**

Healthcare providers are required to report selected communicable diseases, per Arizona Administrative Code R9-6-202. Report communicable diseases to the local health agency (fax numbers below) or through MEDSIS (https://my.health.azdhs.gov). Visit http://azdhs.gov/providerreporting for the list of reportable conditions, this form, and other communicable disease reporting information.

### 1. Complete the Patient Information

<table>
<thead>
<tr>
<th>Patient's Name (Last, First, Middle)</th>
<th>Date of Birth</th>
<th>Race (check all that apply):</th>
<th>Ethnicity</th>
<th>Gender</th>
<th>Parent/guardian (of minors)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>White</td>
<td>Male</td>
<td>(Not necessary for STDs)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Black</td>
<td>Unknown</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Asian</td>
<td>Female</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Spanish</td>
<td>Transgender</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Other</td>
<td>Unknown</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Street Address</th>
<th>City</th>
<th>State</th>
<th>Zip code</th>
<th>County</th>
<th>Reservation</th>
<th>Telephone #</th>
<th>Email</th>
</tr>
</thead>
</table>

### 2. Complete the Reportable Condition Information

<table>
<thead>
<tr>
<th>Diagnosis or Suspect</th>
<th>Illness Onset Date</th>
<th>Risk &amp; Outcome Information:</th>
</tr>
</thead>
</table>

**Patient's School or Occupation:**

- Write the school/facility/employer name in the notes if any of these are checked.
- Healthcare worker
- Food worker/handler
- School/childcare worker
- School/childcare attendance
- Other occupation

<table>
<thead>
<tr>
<th>Risk &amp; Outcome Information:</th>
<th>Outcome</th>
<th>Injection drug user (IDU)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient's School or Occupation</td>
<td>Survived</td>
<td>Died, date:</td>
</tr>
<tr>
<td>Pregnant</td>
<td>Yes</td>
<td>Unknown</td>
</tr>
<tr>
<td>Yes</td>
<td>Unknown</td>
<td></td>
</tr>
</tbody>
</table>

**If STDs, Hepatitis or HIV/AIDS:**

- Patient had sexual contact with:
  - Males only
  - Females only
  - Both
  - Unknown

**If Sexually Transmitted Diseases (STD) or HIV/AIDS:**

- Chlamydia or gonorrhea:
  - UTI with Pelvic Inflammatory Disease
- Chlamydia, gonorrhea, chancroid, syphilis:
  - Sex partner in last 2 months
- HIV/AIDS: Negative HIV test in last 6 months

**STD Treatment:**

<table>
<thead>
<tr>
<th>Date</th>
<th>Drug</th>
<th>Dosage</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

**If Hepatitis:**

- Acute hepatitis
- Symptoms
- Yes
- No
- Unknown

<table>
<thead>
<tr>
<th>Hepatitis Test Results</th>
<th>hepatitis A antibody (anti-HAV)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Post</td>
<td>Neg</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>hepatitis B core antibody (anti-HBc)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Post</td>
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</table>

<table>
<thead>
<tr>
<th>hepatitis B surface antigen (anti-HBsAg)</th>
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<th>hepatitis B DNA/NAAT</th>
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<th>hepatitis C-Viral Load</th>
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**If Tuberculosis:**

- TB signs/symptoms
- Yes
- No
- Unknown

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<tr>
<th>Site of disease</th>
<th>Initial Drug Regimen</th>
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<tr>
<td>Pulmonary</td>
<td>Start date:</td>
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<tr>
<td>Laryngeal</td>
<td>RIPE</td>
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<td>Other extrapulmonary</td>
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| TB infection in a child <6 years old (positive TST/IGRA)? | Yes | No |

### 3. Complete the Facility Information

**Person making this report (Reporter) (Physician or other reporting source):**

<table>
<thead>
<tr>
<th>Name</th>
<th>Reporting Facility</th>
<th>Laboratory (if testing performed)</th>
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<td>Lab Name</td>
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<tr>
<th>Reporter Address</th>
<th>State</th>
<th>Zip</th>
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<tr>
<th>City</th>
<th>Telephone</th>
<th>Email</th>
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Fax numbers for local health departments:
- Apache (860) 804-8448
- Cochise (520) 432-0479
- Coconino (928) 679-7351
- Gila (928) 425-0794
- Graham (928) 428-8074
- Greenlee (928) 865-1922
- La Paz (520) 669-0703
- Maricopa non-STDs (602) 372-8935
- Maricopa STDs (602) 506-6916
- Mohave (928) 718-1579
- Navajo (928) 532-8054
- Pima (520) 838-7538
- Pinal (520) 865-2929
- Santa Cruz (520) 375-7624
- Yavapai (866) 271-9773
- Yuma (928) 317-4620

Version 4-2018
DIOCESE OF TUCSON SCHOOLS
STUDENT MEDICATION CONSENT / LOG

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:

Allergies

Student's Name ___________________________ DOB __________ School ___________________________ Hm Rm Teacher ___________________________

Doctor ___________________________ Phone # __________ Fax # __________ Diagnosis ___________________________

Special Instructions ___________________________ Side Effects ___________________________ Month/Year __________

---

**Signature (Parent/Guardian) ___________________________ Date __________**

**MEDICATION**

- **NAME**
- **DOSE**
- **TIME**
- **ROUTE**

- Record the amount of medication received (i.e. # of pills, amount of liquid) with each initial receipt in the "Notes" Section on the Reverse.
- Record Time medication was given (or Reason not given) and initials in the appropriate boxes.
- If medication is not given, please use one of the following abbreviations to indicate the reason:why:
  - A-absent
  - O-out of medication
  - F-field trip
  - D-discontinued
  - R-refused
  - DW-dose wasted
  - ER-early release day
  - V-vacation/school closed
  - S-Other

Provide explanation in the "Notes" Section on the Reverse side.

**Med Gr or Signature Initials Date for each dose**

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<tr>
<th>Signature/initials: ___________________________</th>
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**Date →**

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# Diocese of Tucson Schools

## Student Medication Consent / Log

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### Notes

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### Documentation of Receipt of Medications

<table>
<thead>
<tr>
<th>Date Received</th>
<th>Medication (Name and dosage)</th>
<th>Number of Tablets</th>
<th>Lot Number</th>
<th>Expiration Date</th>
<th>Received By (Signature)</th>
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0 - 1
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.

☐ Children’s acetaminophen □ Chloraseptic spray/mouthwash □ Calamine lotion
☐ Adult acetaminophen □ Cough drops □ Children’s Benadryl
☐ Children’s ibuprofen □ Tums/Mylanta □ Adult Benadryl
☐ Adult ibuprofen □ Antibiotic ointment □ Heating packs/pad and ice packs
☐ Sterile normal saline eye drops/wash □ Bactine □ 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: ________________
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@ssppucon.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 síéntanse 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
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.
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:

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- 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, avispón, 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 Injector 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.
**Efectos 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.
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 a la piel (la urticaria, la hinchazón, 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, avispón, 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.

☐ 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
## 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, NREMTP  
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  

Revised 12/30/14
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 #
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). Restringe la actividad física y permíta 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. Regístre 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.
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
- alelo 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
- puño 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
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

Number of puffs of albuterol administered (Puffs)

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

Number of puffs of albuterol administered (Puffs)

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:

**This form shall remain on file with the school for a minimum of 3 years.**

O - 7
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 __________________________ (Name) to self-administer the above-named inhaler.
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 ___________________________ 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

## TRAINING RECORD FOR PERSONS DESIGNATED TO ADMINISTER MEDICATIONS TO STUDENTS

**School:** ____________________________  **Trainer:** ____________________________  **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 procedures have 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 health office.

<table>
<thead>
<tr>
<th>Name of Person Being Trained</th>
<th>Date of Training</th>
<th>Policies &amp; Procedures</th>
<th>Signature of Person Receiving Training</th>
<th>Signature of Nurse Giving Training</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Diocesan Medication Policy</td>
<td>Confidentiality of Student Information</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* 1) Right Person 2) Right Medicine 3) Right Time 4) Right Dose 5) Right Route 6) Right Documentation 7) Right evaluation
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:

<table>
<thead>
<tr>
<th>School Nurse informed</th>
<th>Y/N</th>
<th>Name ______________________</th>
<th>Time ________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Principal notified</td>
<td>Y/N</td>
<td>Name ______________________</td>
<td>Time ________</td>
</tr>
<tr>
<td>Physician called</td>
<td>Y/N</td>
<td>Name ______________________</td>
<td>Time ________</td>
</tr>
<tr>
<td>Poison Control called</td>
<td>Y/N</td>
<td>Name ______________________</td>
<td>Time ________</td>
</tr>
<tr>
<td>Parent/Other called</td>
<td>Y/N</td>
<td>Name ______________________</td>
<td>Time ________</td>
</tr>
</tbody>
</table>

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

ADEQ
Arizona Department of Environmental Quality
Janice K. Brewer, Governor
Henry R. Darwin, Director

Main Office
1110 W. Washington St.
Phoenix, AZ 85007
(602) 771-2300
(800) 234-5677
(602) 771-4829 (Hearing impaired)
Web site: azdeq.gov

Prescription Drug Disposal...
A Pain in the Drain
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, non-descript 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 an adverse impact 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

Report to Law Enforcement: Call 911

DIOCESE OF TUCSON

Report to DCS: Call 888-SOS-CHILD (omnit 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 CUSTOMDIAN’S NAME

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

MOBILE OR HOME PHONE NO. WORK PHONE NO.

PARENT, GUARDIAN OR CUSTOMDIAN’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

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Child Abuse Report Form, Diocese of Tucson
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](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](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](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/kidshc](http://american.heart.org/kidshc)

• 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](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](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](https://walkonaz.com)

• **Choose My Plate** is a nutrition-oriented website with several lesson ideas. The website is: [https://www.choosemyplate.gov/kids](https://www.choosemyplate.gov/kids)

• **Always Changing and Growing Up Program** provides puberty lessons for 5th grade and up. website: [www.pgschoolprograms.com](http://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](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](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.