Gila River HEALTH CARE

School Health Services School Year 2021-2022

STUDENT HEALTH INFORMATION SHEET
Gila River Indian Community Schools

Child's Name: _____ Date of Birth: _____ Person ID #: _____ M / F

Parent/Guardian Name: _____ Lives with: Father / Mother /Guardian Other: _____

Physical Address: _____ Phone: _____ Work: _____ Cell: _____

CHILD'S HEALTH HISTORY: Please circle all health conditions that apply to the child:

ADHD	Bleeding Problems	Ear Infections	Heart Surgery date:____	Seizures
Anemia	Blood Transfusion	Hearing Loss Date:_____	History of Anxiety	Sinus Problems
Asthma	Cold Sores	Heart Murmur	HIV/AIDS	Thyroid Problems
Behavioral Issues	Depression	Hepatitis Type:_____	Lung Problems	TB (Tuberculosis
Bladder/Toileting Problems	Diabetes /Prediabetes	High Blood Pressure	Rheumatic Fever	

History of a COVID19 Positive test: If yes please enter date:_____ Hospitalization (circle) : Yes or No

☐ **No Known Allergy**

		(Circle Reaction)	(Epi-Pen Needed)
☐ Yes ☐ No	Food Allergy _____	Rash/Hives or Trouble Breathing	☐ Yes ☐ No
☐ Yes ☐ No	Latex Allergy _____	Rash/Hives or Trouble Breathing	☐ Yes ☐ No
☐ Yes ☐ No	Medication Allergy:_____	Rash/Hives or Trouble Breathing	☐ Yes ☐ No
☐ Yes ☐ No	Other Allergy: _____	Rash/Hives or Trouble Breathing	☐ Yes ☐ No

ANSWER ALL QUESTIONS ABOUT YOUR CHILD'S CURRENT HEALTH-If Yes, please list Reason

☐ Yes ☐ No My child has a **Counselor** or **Case Manager** with GRHC-BHS: **Name:**_____
My child receives behavioral health services from another organization: _____

☐ Yes ☐ No - Is your child currently under medical care? _____
☐ Yes ☐ No - Has your child ever been hospitalized? _____
☐ Yes ☐ No - Past Surgery, please list and date? _____
☐ Yes ☐ No - Activity Restrictions? Please describe: _____
☐ Yes ☐ No - Special Accommodations Needed: _____
☐ Yes ☐ No - Is your child taking any medications at **HOME? (List)**_____
☐ Yes ☐ No - Will your child take doctor prescribed **MEDICATION DAILY AT SCHOOL**? **If Yes,** see your school nurse, you must fill out **MEDICATION CONSENT FORM.**
(List Medications)_____
☐ Yes ☐ No My child is supposed to wear glasses? (circle) Full Time Use / Part Time Use / Reading only
☐ Yes ☐ No My child has seen an eye doctor: **Last Eye Exam Date:**_____ (Glasses Broken/Lost?) circle

I understand and agree that it is my responsibility to notify the school nurse and health providers at GRHC of any changes in the information recorded on this form. I certify that the information I have provided on this School Health Information form is accurate, true and correct.

X _____ X _____ X _____

Print Name of Parent/Guardian | Signature | Date

All records will be maintained in accordance with the Health Insurance Portability and Accountability Act (HIPAA) and Family Educational Rights and Privacy Act (FERPA), as applicable. By signing this release, you authorize and consent to disclosure of health information on a need-to-know basis for the provision of health care services in accordance with HIPAA and FERPA.

SHS Office Use Only RN Initials: IZ: _____ ASIS: _____ MIDAS: _____ NextGEN: _____ HIMs: _____

☐ Blackwater Community School ☐ Casa Blanca Community School ☐ St. Peters Indian Catholic Mission
☐ Sacaton Elementary or ☐ Middle School ☐ MVC School ☐ Gila Crossing Community or ☐ Middle School

Teacher:_____ **Grade:**_____

SCHOOL HEALTH SERVICES CONSENT TO TREAT
Gila River Indian Community Schools

Child's Name: _____ Date of Birth: _____ Person ID #: _____ M / F

EMERGENCY CONTACTS FOR THE SCHOOL HEALTH NURSE OFFICE: If I cannot be reached, school authorities have my permission to contact and release my child to the following 3 individuals if my child becomes ill or is injured:

NAME	Relationship	Phone: Home and Cell
1.		
2.		
3.		

School Health Services (SHS) program includes, but is not limited to, health education, annual health screenings, care and treatment for injury/illness, emergency care, immunization surveillance and monitoring for acute & chronic health conditions.

SHS Registered Nurses will administer routine and emergency medication as needed. SHS Department standing orders are approved by GRHC guidelines and SHS medical director annually.

- I understand that in order for my child to receive prescription medication at school, I must sign a Medication Administration Consent form. All medications must be brought to the school by an adult and must be in the original prescription bottle with my child's prescription label on it. Trained school personnel may administer prescribed medications.
- I understand the school nurse and/or trained school personnel may administer epinephrine intramuscularly to my child in case of a life threatening anaphylaxis emergency.

In case of an accident, or injury/illness, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to contact one of the adults listed above. In the event the adults listed above cannot be reached, the school/school nurse may make arrangements necessary to provide care and treatment for my child, including calling 911. School personnel have my permission to request transport of my child to the nearest emergency room. I understand and agree that I will be responsible for any emergency medical service fees.

SHS: Health Educators, will provide health education classes including, but not limited to: The human body, hygiene, emotional and personal health, nutrition, wellness, lice prevention, anti-bullying, infection prevention and safety.

SHS Health Information:

- I understand, agree and give permission for my child's health information to be shared with GRHC healthcare staff and school personnel as needed, for the safety of my child while he/she is at school. The information may include, but is not limited to, my child's eye glass wear/vision and hearing screening results, and/or health conditions such as asthma, diabetes, seizures, heart condition(s) or severe allergy. I also understand and give permission for my child's healthcare information to be shared with my child's GRHC healthcare provider for the coordination of health services and continuity of care.
- I understand and agree that it is my responsibility to notify the school of any changes in my child's health information recorded on the Health Information Form. I certify the information I have provided on the student health information form is accurate, true and correct. I hereby give consent for my child to receive all SHS program services which are explained above.

My signature indicates that I understand the SHS Parent/Guardian Consent to Treat is for the current academic year (SY 21-22) and in order to receive health services, this consent is required to be completed and signed by the Parent/Guardian.

Print Name of Parent/Guardian	Signature	Date
X _____	X _____	X _____

Gila River HEALTH CARE

School Health Services School Year 2021-2022

Parent/Guardian Consent for Over The Counter and Non-Prescription Medication Administration During School Hours

There are certain procedures to be followed should it be necessary for your child to be given over the counter medications during school hours. Please review and sign this document.

Child's Name: _____ Date of Birth: _____ Person ID #: _____ M / F

ADMINISTRATION OF NON-PRESCRIPTION MEDICATION:

OPT OUT ☐ **NO,** I do not want my child to receive Over The Counter Medication at School

Non-prescription medications or over the counter medications (such as Tylenol, bacitracin etc.) may be administered to students who have written permission from parents/guardians. Homeopathic and naturopathic medication will not be administered at the school. Homeopathic and naturopathic remedies are not FDA-approved for use and are therefore not considered as over the counter medications.

A signed Parent/Guardian Consent for Permission to Administer Over the Counter Medications must be signed and on file with the School Health Services Nurse/Office. Non-prescription medications will be given in a dosage consistent with the child's weight and/or age. All medication will be given in accordance with the GRHC SHS Medical Director Standing Order.

OVER-THE-COUNTER MEDICATIONS: I give the School Nurse RN permission to administer the following over the counter medications: **Acetaminophen Tablets and or Chewable Tablet also known as Tylenol, Bacitracin Ointment, Diphenhydramine Capsule and Suspension also known as Benadryl, Hydrocortisone Cream 1%, Refresh Plus-Eye Lubricant (Carboxymethlcellulose sodium 0.5%), Sterile Isotonic Buffered Solution also known as eye wash.**

OVER-THE-COUNTER LICE SHAMPOO:

OPT OUT ☐ **NO,** I do not want a lice shampoo kit for my child.

Rid Lice Shampoo Kit (Piperonyl Butoxide 4% Pyrethrum extract) or GRHC Pharmacy has in stock for lice shampoo.

Is available only to students who are eligible to receive services at GRHC. If my child has been identified as having head lice while at school I, parent/guardian request to be given a lice shampoo kit, so I may treat my child for lice at home. I understand I will need to pick up the lice shampoo kit from the nurse office in person and sign a form verifying I have received a lice shampoo kit.

I understand my student will not be permitted to carry prescribed or over the counter medications on campus. Student violation of this policy may result in the seizure of medication or other medicinal substances along with disciplinary action by the school. The only exceptions are self-carry of an inhaler or epi-pen and must have a prescription label with the student's name on it. I understand if my child will self-carry emergency medication listed above, a SHS self-administration form must be filled out.

I have read and understand the above and I request and hereby give consent for the GRHC School Nurse RN to assist my child with administering over the counter medication (listed above) when needed for illness or injury. I give permission for the school nurse (RN) to give me a lice shampoo kit, so I may treat my child at home. I understand if I mark the OTC Medication 1st OPT OUT my child will NOT receive OTC medication(s) at school. I understand if I mark the Lice Shampoo 2nd OPT OUT I will NOT be eligible to a receive lice shampoo kit, on behalf of my child.

✘ _____ ✘ _____ ✘ _____

Print Name of Parent/Guardian Signature Date

Gila River HEALTH CARE

School Health Services School Year 2021-2022

Parent/Guardian CONSENT to TREAT for Additional Health Services (Optional)

Gila River Health Care (GRHC) Departments (page 1 of 3)

Child's Name: _____ Date of Birth: _____ Person ID#: _____ M / F

Home Phone: _____ Cell Phone : _____ Work: _____

GRHC- OPTOMETRY: **OPT OUT ☐ NO, I do not want Optometry Services**

I GIVE MY CONSENT FOR MY CHILD TO RECEIVE THE FOLLOWING OPTOMETRY SERVICES:

Treatment/Procedure: Complete Eye Exam with possibility of dilation drops to both eyes, 1 hour duration, with the effect of the drops (mild blur and dilated pupils) lasting several hours (which is normal). Not all children will be dilated each year. I authorize school personnel to provide transportation to the Gila River Health Care Optometry Clinic for an eye examination appointment for my child. I understand that my child may have his/her eyes dilated at this appointment. **I also give permission for GRHC Optical staff,** school or school health staff to assist with the selection of frames.

GRHC- Primary Care Department (PCD)-Clinical AUDIOLOGIST: **OPT OUT ☐ NO, I do not want Audiology Services**

I GIVE MY CONSENT FOR MY CHILD TO RECEIVE THE FOLLOWING AUDIOLOGY SERVICES:

Treatment/Procedure: Complete hearing test, 30 minutes to 1 hour. I authorize school personnel to provide transportation to the Gila River Health Care Audiology Clinic for a hearing examination appointment for my child. If you have any questions, please direct them to the Audiology Department at GRHC (520)796-2710.

My signature indicates I hereby give consent for my child to receive services from **GRHC Optometry and Audiology. I understand if I select OPT OUT my child will not be seen for services.** I understand this consent is in effect for the following GRHC Departments: Optometry, PCD-Audiology and BHSC Program Services the current academic school year **2021-2022.** I understand and agree that my child's information may be shared with GRHC health care staff and school personnel as needed.

✘ _____	✘ _____	✘ _____
Print Name of Parent/Guardian	Signature	Date

Gila River HEALTH CARE

School Health Services School Year 2021-2022

Parent/Guardian CONSENT to TREAT for Additional Health Services (Optional)

Gila River Health Care (GRHC) Departments (page 2 of 2)

Child's Name: _____ Date of Birth: _____ Person ID #: _____ M / F

Home Phone: _____ Cell Phone _____ Work: _____

GRHC-Dental Services-On Site at Schools: **OPT OUT ☐ NO, I do not want Dental Services**

I GIVE MY CONSENT TO THE FOLLOWING DENTAL SERVICES:

☐ Yes ☐ No– Education Program- Education about tooth decay (cavities), gum disease and prevention.
☐ Yes ☐ No– Dental Exam- X-Rays and examination to identify dental problems requiring treatment.
☐ Yes ☐ No– Dental Screening and Topical Fluoride application to teeth.(A visual inspection of the child's mouth and teeth).
Please note: This is **NOT** a Dental Exam. Patients will be referred to the Dental Clinic for a comprehensive Dental Examination with x-rays.
☐ Yes ☐ No– Dental Cleaning & Sealants- plastic coatings to seal teeth & keep bacteria out to prevent cavities.
☐ Yes ☐ No– Root canals, fillings, crowns, removal of baby teeth, use of local anesthesia (numbing)
☐ Yes ☐ No- Does your child have any medical or heart condition that may require medication before dental treatment? If so, list the medical reasons _____

All dental services are being provided by GRHC. All treatment supervised by licensed/credentialed Dentist/Dentist specialist. The school is not responsible or liable for any care rendered on site. All services are optional and require written consent as outlined above. A new consent may be submitted at any time if you change your mind regarding level of services to be rendered. If you have any questions, please direct them to Director of Dental Services GRHC (602)528-1209.

GRHC-Community Outreach Mobile Unit (COMU) On Site at Schools: **OPT OUT ☐ NO, I do not want COMU Services**

I GIVE MY CONSENT TO THE FOLLOWING COMU SERVICES:

Well Child Exams (2-18 years old) when accompanied by parent, Immunizations, Sports Physicals (4-18 years old) when accompanied by parent, Sick Visits, Health Screenings, Laboratory, Health Education and Disease follow-up. I hereby give consent for my child to receive medical care by the Gila River Health Care Pediatric Mobile Unit Family Nurse Practitioner. I understand that the medical treatment plan will be discussed with me and/or sent home with the patient. I also understand that I may be able to reach the Family Nurse Practitioner through her work cell phone at (520) 610-2379 for any questions.

My signature indicates I hereby give consent for my child to receive services from **GRHC Dental and COMU. I understand if I select OPT OUT my child will not be seen for services.** I understand this consent is in effect for the following GRHC Departments: Dental Mobile Unit and COMU for the current academic school year **2021-2022.** I understand and agree that my child's information may be shared with GRHC health care staff and school personnel as needed.

Print Name of Parent/Guardian	Signature	Date
✘ _____	✘ _____	✘ _____

Parent/Guardian CONSENT to TREAT for Additional Health Services (Optional)

Gila River Health Care (GRHC) Departments (page 3 of 3)

Child's Name: _____ Date of Birth: _____ Parent/Guardian: _____

Home Phone: _____ Cell Phone _____ Work: _____ M / F

BEHAVIORAL HEALTH SCHOOL COUNSELING PROGRAM (Optional)

Gila River Health Care (GRHC) has established a Behavioral Health School Counseling (BHSC) Program with your child's school to provide support/counseling services during school hours intended to promote social emotional wellness, educational progress and success. If you would like your child to be eligible to receive these services, you will need to complete the "opt in" section below. If you do not want your child to receive these services, you may opt out of the program by completing the "opt out" section below. Your decision to opt in or out of the program will not prevent your child from receiving services in crisis situations.

Please check *ONLY ONE BOX* below

OPT IN TO THE BHSC PROGRAM: (Check only 1 of the 2 boxes)

☐ I want my child to be eligible receive support/counseling services as needed through the BHSC Program.

I authorize the GRHC BHSC Program to provide support/counseling services (in person or through virtual means), to the extent consistent with Program requirements and in coordination with my child's school, when determined appropriate to support my child's social-emotional wellness, educational progress and success.
I understand that if it is determined that my child would benefit from ongoing behavioral health services such as ongoing groups, one-on-one therapy or referrals to other behavioral health services outside the BHSC Program, such services will be discussed with me and a separate consent form will be sent home with my child before any of these services are provided. I authorize the BHSC Program to share my child's information with school personnel only as necessary to facilitate the services hereunder (including providing a copy of this form to the school) and to protect the health and safety of my child and others.

OPT OUT OF THE BHSC PROGRAM: (Check only 1 of the 2 boxes)

☐ I do not want my child to be eligible to receive support/counseling services through the BHSC Program. I understand that this means that my child will not receive behavioral health services (except in crisis situations) during school hours for the 2021-2022 school year unless consent is provided at a later time. I authorize the BHSC Program to provide a copy of this form to my child's school.

✘	✘	✘
Print Name of Parent/Guardian	Signature	Date

Gila River Health Care Contact Information:

Hu Hu Kam Memorial Hospital: 602-528-1200 / 520-562-3321
Komatke Health Center: 520-550-6000
Hau'pal (Red Tail Hawk) Health Center: 520-796-2600

Gila River
HEALTH CARE

School Health Services

School Year 2021-2022
Lice Information for Parents/Guardian
Gila River Indian Schools

- I understand it is my responsibility to keep my child's hair free of head lice. I understand I need to have my child's hair cleaned in a timely manner to reduce school absence.

- I will review and follow the school's lice policy/guidelines in my student's school handbook for nits, lice, or head sores related to lice infestation.

- The school nurse or school staff will contact me either by phone or letter if my child is found to have nits, lice, or head sores related to lice infestation. If I treat and comb out my child's hair, I may send my student back to school the next day. A pharmacy referral for lice shampoo, lice treatment options and a 14 day Lice educational flyer will be sent home with my child found to have head lice.

- Any GRHC Pharmacy (HHK, RTH or KHC) will give you and/or your family lice shampoo at your request. (You do not need to be seen by a doctor or have a referral).

- The **Parent/Guardian Consent for Over The Counter and Non-Prescription Medication Administration During School Hours Form,** must be signed. It is located in the SHS Health Consent Packet. In addition, the parent/guardian MUST pick up the lice shampoo kit, in person, from the nurse office at your child's school. Contact the school nurse for more information.

- The Gila River Health Care Public Health Nursing Department can assist the family with head lice removal at the request of the family.