



STUDENT EMERGENCY CARD
2017-2018

Student Name: (Last) (First) (MI) (Date of Birth) (Age) (Grade)

Form with two columns for Father/Guardian and Mother/Guardian information, including Name, Address, Home Phone, Work Phone, Cell Phone, Employer, and Email.

**Please circle the best way to contact you.

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PERSONS TO CONTACT IN CASE OF EMERGENCY WHEN PARENT/GUARDIAN CANNOT BE REACHED

Table with 6 columns: (Name), (Home), (Work), (Cell), (Relationship), (Employer). Three rows for contact information.

MEDICAL/HEALTH HISTORY INFORMATION

***Please read carefully and fill in the necessary information. This information is confidential but may be necessary to share among pertinent faculty for activities which overlap.

ALLERGIES (Medications, Food, Insect Bites, etc.):

Blank line for allergies information.

Medical Conditions, Diagnoses:

Medications taken daily (at home or school) or as needed. Include name, dosage and frequency:

Daily Monitoring or Procedures (glucose, nebulizer, etc.):

Doctor's Name: Office Phone: Emergency Phone:

Dentist's Name: Office Phone: Emergency Phone:

Insurance Carrier: Group Policy #:

I, _____, do hereby authorize the School Administration to render first aid for illness or injury to my child named above. In the event of a medical emergency, I authorize the School Administration to have my child transported to the nearest available hospital/emergency care center for emergency medical or surgical treatment and to contact one of the persons listed above. I further authorize the release of the above medical information to all medical personnel providing treatment. I agree to be solely responsible for the payment of all expenses incurred in such an emergency.

I do hereby release, hold harmless and indemnify The Regis School, the Regis Board of Directors, the Head of School, Mr. Dennis Phillips, and his successors in office, and all officers, agents, employees or representatives ("Released Parties") from any and all liability, claims, losses or expenses arising from personal injury, death or loss of or damage to property arising from any medical treatment received and/or transportation to the nearest available hospital/emergency care center, including any claims allegedly caused or contributed to by the negligence or willful misconduct of the Released Parties.

Signature of Parent/Guardian

Date Signed



Name: _____
(Last) (First)

DOB: _____

IMMUNIZATION RECORD 2017-2018

Age: _____ Grade Entering: _____

PLEASE NOTE: A complete record of immunizations must be on file before your child may attend classes. Please have your physician complete this form or send a copy of your child's immunization record(s) signed by a physician. This must be done each school year as requirements change. **PLEASE SEND UPDATES TO THE CLINIC DURING THE SCHOOL YEAR.**

Physicians are requested to write a note concerning any health-related problems that your child may have in order that the school will be informed of special needs, circumstances and/or restrictions for your child.

Complete dates (e.g. day, month and year) and validation by a physician or health clinic or provide a copy (preferred).

1. **DPT SERIES (5)** #1 _____ #2 _____ #3 _____
3PK & 4PK: 4 doses
Kindergarten: 5th dose #4 _____ #5 _____
2. **TDAP BOOSTER** #1 _____ #2 _____
7th grade entry requires 1 Tdap booster if 5 years have elapsed since last dose.
8th grade entry requires 1 Tdap booster if 10 years have elapsed since last dose.
3. **POLIO** #1 _____ #2 _____ #3 _____
3PK & 4PK: 3 doses
4. **POLIO BOOSTER**
Kindergarten: 4th dose
Required for K-12 #4 _____
5. **MMR** #1 _____ #2 _____
3PK: 1 dose; K-7: 2 doses
6. **TB SKIN TEST** _____ **RESULTS** _____ : _____ **RESULTS** _____
(or completed TB Screening Questionnaire each year)
7. **CHEST X-RAY** _____
8. **HibCV** #1 _____ #2 _____ #3 _____ #4 _____
9. **HEPB** #1 _____ #2 _____ #3 _____
3PK, 4PK, and K-12: 3 doses
10. **VARIVAX** #1 _____ #2 _____
3PK, 4PK: 1 dose
K-12: 2 doses
11. **HEPA** #1 _____ #2 _____
3PK – 7th grade entry: 2 doses
12. **PNEUMOCOCCUS** #1 _____ #2 _____ #3 _____ #4 _____
13. **MENINGOCOCCAL** _____
7th & 8th grade entry: 1 dose

Physician's Signature: _____ Date: _____

Physician's Printed Name: _____



Name: _____
(Last) (First)

Date: _____

Date of Birth: _____

Grade Entering: _____

**ADMINISTRATION OF MEDICATION
HEALTH FORM
2017-2018**

**Note to Parents/Guardians: We do not keep "stock" medications. Parents/Guardians must supply all non-prescription medication with written instructions on this form.

Prescription medications must (1) be supplied in the original prescription container with the pharmacy label and (2) be signed by the physician.

Allergies (medication, food, etc): _____

NAME OF MEDICATION: _____

Reason Medication Prescribed: _____

Please circle: Tablet Pill Capsule Liquid Inhalant

Other (Specify): _____

Dosage: _____

Frequency, or what time: _____

Start Date: _____ Stop Date: _____

Physician's Signature

Physician's Phone Number

Physician's Name (Print)

Please Read Carefully and Initial:

_____ I agree to hold the school harmless for the proper administration of medications provided by parent/guardian and for adverse drug reactions or side effects. I am aware that lay personnel administer medications.

_____ I AGREE TO PROVIDE ALL MEDICATION FOR MY CHILD. I agree to be responsible for maintaining adequate supply of medication at the school to meet my child's needs.

_____ I agree to notify and educate appropriate school personnel of any condition my child has which would require extraordinary knowledge and measures (food and drug allergies, asthma, diabetes, seizure disorder, diabetes, etc.).

_____ I agree to not allow my child to keep medications with him. All medications (prescription, OTC) are to be handed to the nurse, clinic staff, or administrative personnel by the parent, not brought by the student.

_____ I am aware that 911 will be called to take care of my child if the condition is considered an emergency by school personnel.

Signature of Parent/Guardian

Date



STUDENT TB SCREENING QUESTIONNAIRE 2017-2018

Name of Child: _____

Grade: _____ Date: _____

Tuberculosis (TB) is a disease caused by TB germs and is transmitted by an adult person with active TB lung disease. It is spread to another person by coughing or sneezing TB germs into the air. These germs may be breathed in by the child.

Adults who have active TB disease usually have many of the following symptoms: cough for more than two weeks duration, loss of appetite, weight loss of ten or more pounds over a short period of time, fever, chills, and night sweats.

A person can have TB germs in their body but not have active TB disease (this is called latent TB infection or LTBI).

Tuberculosis is preventable and treatable. TB skin testing (often called the PPD or Mantoux test) is used to see if your child has been infected with TB germs. No vaccine is available to use in the United States to prevent tuberculosis. The skin test is not a vaccination against TB.

We need your help to find out if your child has been exposed to tuberculosis. All information obtained herein will be kept in strict confidence. Please mark the appropriate answer for the following four questions.

- 1. TB can cause fever of long duration, unexplained weight loss, a bad cough (lasting over two weeks), or coughing up blood.

As far as you know:

- a. Has your child been around any adult with these symptoms or problems?

Yes No

- b. Has your child had any of these symptoms or problems?

Yes No

- c. Has your child been around anyone sick with TB?

Yes No

- 2. Was your child born in or has your child traveled in the past year to Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe or Asia for longer than 3 weeks? Born in: _____ Traveled: _____

Yes No

If so, which country/countries? _____

- 3. To your knowledge, has your child spent time (longer than 3 weeks) with anyone who is/has been an intravenous (IV) drug user, HIV infected, in jail or prison or recently came to the United States from another country?

Yes No

- 4. Has your child ever had a positive TB skin test?

Yes No

If so, please specify date - _____

Signature of Parent/Guardian _____

Date _____