

SANTA FE INDIAN SCHOOL

Department of Student Wellness

Santa Fe Indian School School Health Center

** TEAR THIS COVER OFF AND KEEP FOR YOUR RECORDS**

This packet is for the Santa Fe Indian School *Health Center* (School Nurses Office). We require these documents to be updated annually.

School Health Center Services:

- Nursing assessment and triage for student illness and injury.
- Referrals
- Provide some over the counter medications with (parental consent)
- Prescription medication administration (<u>ONLY WITH A CURRENT</u> <u>MEDICATION AUTHORIZATION FORM SIGNED BY PRECRIBING PHYSICIAN ON</u> <u>FILE</u>)
- Communication with parents/guardians about student health needs.
- Confidential health services (parental consent not required):
 - STD Prevention
 - Pregnancy Testing
 - Contraceptive
 - Drop-In counseling services

School Health Center 505-216-7418

STUDENT HEALTH HISTORY FORM AND RELEASE OF INFORMATION

Student Name	irst Nama)		DOB		Grade	e	F	M
(Lust Nume, F	irst Nume)							
Your student's health histo	ory is importan	<mark>t to provide t</mark>	he best care	e at scho	ool. It is the responsibilit	y of the p	arent/guardian	to notify
the school of NEW or EXIST	TING health co	ncerns. If yoເ	ır student is	prescrib	oed medication or a tred	ıtment at	school, it is the	
esponsibility of the paren	t or guardian t	o notify the s	chool and p	rovide t	he medication or necess	ary equip	ment for use at	school.
<mark>Please be advised that the</mark>	health center	<mark>staff may ası</mark>	<mark>k for more d</mark>	ocumen	tation on your student's	health h	<mark>istory.</mark>	
Last Dhysical Fyam			Lloalthaara D	rouidor/I	-a ciltir			
Last Physical Exam Healthcare P Last Dental Exam Dental Provio		der/Facili	-aciltiy ity					
Last Vision					ity			
My student has the following	g (NEW or EXIST	ING) medical	condition(s)	(Check a	l that apply)			
HEAD	EVEC					ENDOG	DINE (DI GOD	
Concussion	EYES	•			IE/MUSCLE	_	RINE/BLOOD	
loss of consciousness)		ion Concerns asses/Contacts		JOI		_	betes/TYPE I	
loss of consciousness)	_	ion Loss			Muscular concerns		betes/TYPE II od Disorder	
Concussion	(bc	oth/one eye)			Knee, back, bone or joint concerns	_		
(no loss of consciousn	less)	her			Scoliosis	_ O.	ner	
Migraines (diagnosed)			· 		Other			
Frequent Headaches				_				
Seizures								
Other						EMOTIO		
FAR ANGE TURO AT ANGUIT		ABDOMEN/INTESTINAL			ALLERGIES		OCICAL	
EAR/NOSE/THROAT/MOUTH	<u>URINA</u>	<u>KY</u>			Anaphylactic shock	PSYCHOI Me	ntal/emotional	
☐ Frequent earaches/infection	ons 🗆 Fi	requent			Any Anaphylactic		icerns	
☐ Hearing loss/condition		Stomachaches			symptoms to (food, nuts,	☐ Oth	ner	
☐ Hearing aid	□ υ	rinary or Bowel			stings etc.)			
Speech problems	Co	oncerns			Allergies (airborne, animals, medications,			
Other	_ 🗆 0	ther			food, latexes. etc.)	<u>OTHI</u>	<u>ER</u>	
SKIN	CHROMOSOME/	HΕΔR	T/LUNG		Allergies, Latex	□.		
	GENETIC		Asthma		Lactose Intolerance			
_	□ Down	_	Heart		Other			
□ Other	Syndrome		Condition					
	Other		Other					
			Julie1					
f checked please give a briej	f description:							
j checkeu pieuse give u briej	acscription.							
\square My child has \underline{N}	<u>NO</u> (new or exist	ing) health co	ncerns. (By c	hecking t	his box, you agree to com	municate v	with the school re	egarding ne
health concern	ns during the sch	nool year.)						

School Year: <u>2021-2022</u>

nee	ds to ho	ive a Medication Authorization form. This form must be signed by the parent/guardian and prescribing provider (MD,
DO,	ANP, P	A etc.) All Medications need to be in a properly labeled pharmacy container.
		LONG-TERM Prescribed Medication
		SHORT-TERM Prescribed Medications
*	My chi	ld will require the following emergency medication(s) at school, check all that apply (parent/guardian must provide):
		Epinephrine (EpiPen or Auvi-Q)
		Rescue Inhaler (Albuterol)
		Glucagon
*	My chi	ld will require the following plan or other treatment at school (check all that apply):
		Student Allergy/Anaphylaxis Action Plan
		Asthma Action Plan
		Individualized Healthcare plan – Diabetes with/without injection
		Individualized Healthcare plan – Diabetes with pump
		Seizure Action Plan
		Other treatment in school
		Information: The disclosure of health information within the school is limited to information necessary to serve the student's health
		on interests. Your voluntary agreement gives permission for the school staff to be informed of precautions and procedures
nec	-	protect your child at school and foster academic success.
		GREE
		ISAGREE
	Parent,	Guardian Signature Date

Medication Administration – Any prescription medication (long/short term) that will need to be administered by the school nurse,

SANTA FE INDIAN SCHOOL HEALTH CENTER

AUTHORIZATION TO ADMINISTER PRESCRIBED MEDICATION

PART I - TO BE COMPLETED BY THE PARENT/GUARDIAN

I hereby request and authorize designated and properly instructed school personnel to administer prescribed medication as directed by the prescribing physician (PART II below). I certify that I have legal authority to consent to the administration of prescribed medication following the physician's order. I understand additional prescriber/parent authorizations will be necessary for each medication to be administered, and if the dosage off the medication is changed. If necessary, I authorize the designated school health care official to communicate with the prescriber or the student's health care provider as allowed by HIPAA.

STUDENT INFORMATION			651.1		_
Student Name:			of Birth:	Gender: M	F_
LAST	M.	FIRST			
Grade: School Year:	Height (inche	s): Wei	-		
List all medication(s) student is tak	ing, including over the -co	ounter medication(s):			
List any known drug allergies/react	tions:				
Parent/ Guardian Signature:		Date:	Phone #: _	_	
PART II – TO BE COMPLETED	BY THE PROVIDER (PL	EASE USE A SEPARA	TE FORM FOR EA	CH MEDICATI	ON)
NAME OF MEDICATION:		Diagnosis:			
DOSAGE:	Time(s)/ Frequency to	be given:			
Route of Administration		PRN: YES NO			
IF PRN, (SIGNS, SYMPTOMS):					
Side Effects:					
Begin Medication Date:	Stop Medication Date:				
Special Instructions:					
Is medication a co	ontrolled substance? YES	NO			
_	y self-carry/self-administration				
	en instructed in the proper se red? YESNO _	If-administration medicine	? YES NO		
Prescriber's authorization for self-carry		argency medication:			
Tessiner sauthonization for sen early	yysen danimistration of em		SIGNATURE		_
Prescriber's NAME/ TITLE (Please Print):		0.0		
Phone Number:			_		
Prescriber's Signature			Date:		

SFIS HEALTH CENTER NURSE SIGNATURE:

Date: _____