2023/2024 Academic year

Health Office Registration Forms:
Checklist for students

Form deadline: Friday, July 21, 2023

_____**Over the Counter Medication Distribution Form:** This form is OPTIONAL, but understand that no medication will be given to your child unless this form is signed by a Physician and a Parent. (PARKER PEDIATRIC PATIENTS need only a parent signature but please write Parker Peds on the physician signature line.) Please sign the declination line if you do not want for your child to be given medicine during the school day.

_____**Immunization Record:** All new students entering Ave Maria Catholic School must provide proof of immunization. If a student has not received an immunization due to medical or personal beliefs a declination form must be provided to the health office. **COLORADO LAW requires that the school must receive complete immunization information for each student prior to the first day of school in order for your child to attend class.**

_____**General Health Appraisal**: ***All new students*** to the school (**including all Kindergarten students)** are required to have a general health appraisal form filled out by a provider (MD, PA, or NP).

The following students MUST have a new General Health Appraisal:

__ all Preschool students(3 year olds)
__ all Junior Kindergarten students (4 year olds)
__ all Kindergarten students
__ all Sixth (6th) grade students
__ all New students to the school

_______**Care Plans (Asthma, Allergy & Anaphylaxis, Diabetes):** These forms must be completed and signed by you and your child's physician if the child requires an inhaler, epi-pen, insulin etc. *Children with diabetes can bring their care plan from the Barbara Davis Center or one provided by their doctor.*

_______**Self Carry Contract:** This form must be completed if your child will be responsible and carry their own inhaler while at school. Your child will also need a completed Care Plan.

_______**Prescription Medication Authorization form**: If your child will require prescription medication while at school, (meds that are not already addressed in a care plan), then this form needs to be completed by the parent as well as their physician.

For questions, please contact the Health Office.
Tammy Nault BSN RN & Jill Lillehoff BSN RN
Ave Maria Catholic School Nurses
720-842-5403 or nurse@avemaria.school

Revised 5.22.23

Over-The-Counter Medication Distribution
K-8 2023-2024 Optional

Name of Student ____

The School Nurse or Health Office Aides at Ave Maria Catholic School will dispense the following over-the-counter medications in the following dosages if a student exhibits symptoms that indicate the need for a particular medication. ***The parent/guardian and physician must sign in agreement with the medications and dosages described below.***
All oral medication is weight based.

- Acetaminophen (dosage dependent upon the student's weight) for severe headaches and or fever.
- Ibuprofen (dosage dependent upon the student's weight) for muscle strains and pain.
- Benadryl (12.5-25mg) for allergic reactions (itching, hives, etc.) to food and environmental allergens.
- Cough drops as needed for throat irritation.
- 1-2 Tums Chewable tablets for indigestion symptoms.
- Saline Drops as needed for eye irritation.
- Calamine lotion, anti-itch cream/gel/spray (Benadryl/Cortaid) or topical antibiotic cream for skin irritation and protectant.
- Sunscreen

By Signing, I give permission for the student to receive the above medications and dosages as indicated by symptoms, and administered by the School Registered Nurse or Health Aids.

» **Physician Signature/Office Stamp** **Date:**____________________

□ **Check here if your child goes to Parker Pediatrics**

» **Parent/Guardian Signature:**_______________________________ **Date:**______________________

» **Parent/Guardian Declination:** ________________________________ **Date:** _____________________

Dear Parents,

The form, **PHYSICIAN/PARENT PERMISSION TO GIVE “OCCASIONAL” OVER-THE-COUNTER MEDICATIONS DURING SCHOOL HOURS,** is the medication permission form we will be using for the school year.

This form must be signed by you and your child’s physician at the beginning of each school year. Unless your students go to Parker Pediatrics, please have your individual physician sign the form because we do not have a medical director to sign and approve the use of medications at school. This form **MUST** be on file at **AMCS PRIOR** to administering any “over-the-counter” medications to your child, ***this includes Tylenol. No verbal approvals will be allowed.***

If prescription medications are to be given at school, the **STUDENT PRESCRIPTION MEDICATION RELEASE** will need to be completed by the physician. Please download this form and return to the health office after it is signed by your physician

For Parker Pediatric Families. Parker Pediatrics will be contacted for an order authorizing the administration of Acetaminophen and Ibuprofen medications; this order is to be used for the Parker Pediatric patients of Ave Maria. Parker Peds will also authorize the use of Benadryl in the event of an urgent/emergent need to allergic reaction**.** Parker Pediatrics does not authorize the use of over-the-counter cold/cough preparations to be administered at school because there are many long acting medications which can be used instead and given prior to school.

If your child(ren) are patients of Parker Pediatrics please sign the “over-the-counter” medication form provided by the school indicating authorized medications which may be administered. In lieu of a physician signature, please write Parker Pediatrics. **Please do not take our form to Parker Pediatrics.**

If you have further questions regarding medication administration at Ave Maria please contact me.

Thank you for your cooperation,
Tammy Nault BSN RN & Jill Lillehoff BSN RN
Ave Maria Catholic School Nurses

Student Medical and Surgical Release Form
K-8 2023/2024

DATE_______________________

FAMILY NAME____

ADDRESS____

CHILD'S NAME: GRADE: 23/24 SY AGE:

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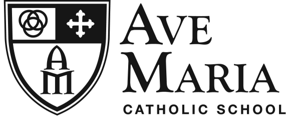
I, as parent or legal guardian of the above mentioned minor child (ren), hereby give my consent to emergency medical, surgical, or dental treatment in the event of accident, injury, sickness or other event of an emergency nature which would require immediate treatment of the above stated child (ren). I understand that Ave Maria School will notify me as soon as possible of its actions with regard to such treatment, and that Ave Maria School will attempt to reach me prior to such treatment if circumstances permit.

I hereby release Ave Maria School and its employees, including faculty, staff, volunteer staff and maintenance personnel, from any liability by reason of the exercise of emergency medical, surgical or dental treatment of the above listed child (ren), pursuant to this release, except liability for bad faith in the exercise thereof.

I further understand that there is no limitation to the treatment that may be used, as long as it is within the standards of generally accepted medical, surgical, or dental practice, and I have listed hereunder any limitations thereto with respect to same concerning the above listed child (ren). *(Such as prohibitions to treatment, specific allergies, drugs, etc.)*

Parent/Guardian Signature:____



Student Health Information
K-8 2023/2024

Your child's learning depends upon good health and regular school attendance. To assist in providing health services at school, please complete the following and return to the School Nurse.

Student Name ______________________________Grade ___________ Birth date___________

Allergies	No	Yes	To drugs, food, insects, pollen? Please list ____________________ Has the allergy required emergency action in the past?
Asthma	No	Yes	Triggered by ___________Treatment ______________ Diagnosed by Dr. Date
Attention Concerns (ADHD or ADD)	No	Yes	Medications ________________________________
Diabetes	No____	Yes _____	Takes Insulin? No _________ Yes_____________
Epilepsy/Seizures	No	Yes	Type of Seizure ______________________________ Date of last seizure Medication
Heart Condition	No	Yes	Describe_____________________________________ Any physical restrictions? Medication
Kidney Disease	No	Yes	Describe ______________________________________
Bone or Joint Problems	No____	Yes _____	Describe ______________________________________ Any physical restrictions? ______________________
Eye Problems	No	Yes	Glasses? ______ Contacts? ______ Lazy eye? _______
Ear Problems	No	Yes	Frequent infections? _________ Tubes? __________ Hearing Loss? Rt Lt Hearing aid
Serious Injuries/Illnesses	No	Yes	Describe ____________________________________
Surgeries/Hospitalizations	No____	Yes _____	Describe ____________________________________
Developmental Concerns	No	Yes	Physical/Motor? _________ Speech/Language? ________
Other Health Concerns	No	Yes	Describe ______________________________________

Medications

Is your child currently taking any medications? No _______ Yes _______

Name of medication(s) ____

Dosage ____

Reason ____

Will your child require medication during school hours? No _______ Yes _____

Medical Procedures

Will your child require any specialized medical procedures during school hours? No _______ Yes _______

If your student requires medication or medical procedures at school, please obtain the necessary permission forms.

Has your child received any of the following special education services in the past?

Speech/Language No ___ Yes ___ Physical/Occupational Therapy No ___ Yes ___

Learning Difficulties No ___ Yes ___ Behavior/Emotional No ___ Yes ___

Reading No ___ Yes___

Signature of Parent/Legal Guardian ___________________________________ Date ____________