DUE BACK TO SCHOOL BY: February 6th, 2015.

Request for administration of medication by camp personnel:

1. **A separate request form is to be completed for each medication sent to camp.**
2. **Medication must be in original container, not expired, and properly labeled.**
3. **Routine meds will be given at meal times. It is the student's responsibility to come to the nurse or designated personnel for meds.**
4. **If your child requires a nebulizer then please send one from home with students name on it.**
5. **If your child requires a nebulizer or inhaler then an Asthma action plan must be completed by child's physician.**

STUDENT'S NAME______________________________________ **DOB**_______

MEDICATION__________________________ **AMOUNT** ________ **TIME**_____

Condition for which the medication is to be given and/ or instructions ______________

____

____

Physician / Dentist Signature____________________________ **Date** ___________

Office Number _______________________ **Fax Number** ____________________

The physician or dentist must be licensed to practice in the United States. Physician signature is required for controlled substances, over the counter medication, long term therapy, or changes in the original prescription. ****All medications must be in their original container and cannot be expired.****

I request and authorize the Stephenville ISD to administer the medication as prescribed. I understand that the school administrator may designate any qualified person or persons to administer this medication. I also understand that although a reasonable attempt will be made to remind the student, it is expected that the student will be responsible in most situations to arrive for medication. Medication doses that could be given at home will not usually be given at school. Medications for short term therapy scheduled for three times daily, may generally be given at home. All medications must be in their original container.

I also authorize the school's registered nurse (RN)/licensed vocational nurse (LVN) to consult with the prescribing physician to clarify this medication order, or in the interest of the student's health, to discuss his/her response to the prescribed medication as required by the Texas Nurse Practice Act. It is expected that the school nurse will first attempt to notify a parent /guardian should such contact become necessary.

Parent/Legal Guardian Signature____

Telephone______________________________________ **Date**_____________

SISD STUDENT ASTHMA ACTION PLAN

(To be completed by the physician)

Name: ______________________________ Grade: _______ Teacher: ______________________

Parent/Guardian: ______________________________ Emergency Phone: ______________________

Physician: ______________________________ Phone: __________________ School Year: ______________

DAILY ASTHMA MANAGEMENT PLAN

1. Identify the things which start an asthma episode.

___exercise ___respiratory infections ___animals ___change in temperature ___strong odors or fumes ___chalk dust ___carpets in the room ___pollens ___molds ___other ______________________________

2. Control of school environment.

List any environmental control measures and/or dietary restrictions that the student needs to prevent an asthma episode.

____

3. Peak Flow Monitoring

Personal best peak flow number ______________ Monitoring times: _________ _________ _________

4. Daily Medication Plan

	Name	Amount	When to Use
1.			
2.			
3.			
4.			

EMERGENCY PLAN

Emergency action is necessary when the student has symptoms such as ______________________________ ______________________________ or a peak flow reading of ______________________________.

1. Steps to take during an asthma episode:

1) Give medications as listed below.
2) Have student return to classroom if ______________________________
3) Contact parent if ______________________________
4) Seek emergency medical care if the student has any of the following:
   - *No improvement 15-20 min. after initial treatment with medication & parent cannot be reached.
   - *Peak flow of ________________.
   - *Hard time breathing with:
     - Chest and neck pulled in with breathing
     - Child is hunched over, struggling to breathe
   - *Trouble walking or talking
   - *Stops playing and can not start activity again
   - *Lips or fingernails are gray or blue

2. Emergency Asthma Medications *(Indicate how often medications may be repeated.)*

	Name	Amount	When to use
1.			
2.			
3.			

3. THIS STUDENT _______MAY _______MAY NOT CARRY AND SELF ADMINISTER THE INHALED MEDICATIONS I HAVE PRESCRIBED.

______________________________ ______________

Physician Signature — Date

______________________________ ______________

Parent Signature — Date

Stephenville Independent School District
Stephenville, Texas
Health Form

Name:____ Grade:__________
Last First Middle

Date of Birth: ____________________ Parent's Contact Number: ____________________

Family Doctor: ____________________ Phone: ____________________

ALLERGIES: (Be Specific-Indicate by Name)

FOOD____

Type of reaction experienced from food allergy ____________________ Circle one: ☐ Mild ☐ Anaphylactic

INSECTS____

Type of reaction experienced from insect allergy ____________________ Circle one: ☐ Mild ☐ Anaphylactic

DRUGS____

Type of reaction experienced from drug allergy ____________________ Circle one: ☐ Mild ☐ Anaphylactic

OTHER ____

Type of reaction experienced from this allergy ____________________ Circle one: ☐ Mild ☐ Anaphylactic

List all medications your child takes:

CIRCLE OR CHECK HEALTH PROBLEMS EXHIBITED IN YOUR CHILD:

- ☐ No Health Problems
- ☐ ADD/ADHD
- ☐ Asthma
- ☐ Bladder/Kidney (Specify) ____________________
- ☐ Blood Disorder (Specify) ____________________
- ☐ Blood Pressure Problems
- ☐ Cancer (Type) ____________________
- ☐ Cerebral Palsy
- ☐ Chicken Pox __________ (Month&Year)
- ☐ Cystic Fibrosis
- ☐ Dental/Braces ☐ yes ☐ no
- ☐ Diabetes (check: ☐ Type I ☐ Type II)
- ☐ Emotional Disorders
- ☐ Fainting
- ☐ Hearing Loss (check: ☐ Aids ☐ Implants)
- ☐ Heart Condition (Specify)____________________
- ☐ Headaches
- ☐ Hospitalizations/Surgery or Illness (Specify date & type) ____________________
- ☐ Neuro/Muscular/Orthopedic/Fractures (Specify date & type) ____________________
- ☐ Nosebleeds
- ☐ Pregnancy (Due Date)____________________
- ☐ Seizure Disorder
- ☐ Serious Accident/Injury (Specify date & type) ____________________
- ☐ Speech Problems
- ☐ Ulcers
- ☐ Vision Defect/ Wears Correction ☐ Yes ☐ No

Additional information to share with the nurse:

If, in the judgment of any representative of the school, the above student should need immediate care and treatment as a result of any injury or sickness, I do hereby request, authorize and consent to such care and treatment as may be given said student by any doctor, trainer, nurse, or school representative, and I do hereby agree to indemnify and save harmless the doctor, the school and any school representative from any claim by any person whomsoever on account of such care and treatment of said student. I give my permission for the physicians of the above named student to release information on health problems to the Stephenville Independent School District and for the School's Nurse to consult with his/her physicians in the interest of the student's health.

Si a juicio de cualquier representante de la escuela, el estudiante ya mencionado debe necesitar atención inmediata y tratamiento como resultado de cualquier lesión o enfermedad, por la presente solicitud, autorización y consentimiento para dicha atención y tratamiento, se puede proveer al estudiante por cualquier médico, entrenador, enfermera, o representante de la escuela, y yo por la presente se compromete a indemnizar y eximir de responsabilidad al médico, la escuela y cualquier representante de la escuela de cualquier reclamo por cualquier persona quien a causa de esa atención y el tratamiento de dicho estudiante. Doy mi permiso para que los médicos del estudiante ya mencionado, compartir información sobre los problemas de salud al Distrito Independiente Escolar de Stephenville y para la Enfermera Escolar consultar con sus médicos en el interés de la salud del estudiante.

Signature of person who has Legal Custody or Guardianship ____________________ Firma de la persona que tenga custodia legal o tutela ____________________ Date/Fecha ____________________

01.07.2014

Spanish on back →

Distrito Escolar de Stephenville
Stephenville, TX
Información de Salud

Nombre: ____ Grado: ______________

Apellido Primer Segundo

Fecha de Nacimiento: ______________________ Número de Contacto del Padre: ______________

Doctor Familiar: ______________________ Teléfono: ______________________

ALERGIAS: (Sea específico-indicar por nombre)

ALIMENTOS ____

Tipo de reacción en caso de alergia alimentaria ______________________ marque uno: ☐ leve ☐ anafiláctico

INSECTOS ____

Tipo de reacción en caso de alergia a insectos ______________________ marque uno: ☐ leve ☐ anafiláctico

MEDICINAS ____

Tipo de reacción en caso de alergia a medicinas ______________________ marque uno: ☐ leve ☐ anafiláctico

OTROS ____

Tipo de reacción en caso de esta alergia ______________________ marque uno: ☐ leve ☐ anafiláctico

Lista todos los medicamentos que toma su hijo/a:

____

CIRCULE O MARQUE ALGUNOS PROBLEMAS DE SALUD MANIFESTADOS EN SU HIJO/A

☐ No hay Problemas de Salud
☐ ADD/ADHD
☐ Asma
☐ Vejiga/ Riñón (Especifique) ______________________
☐ Trastorno de Sangre (Especifique) ______________________
☐ Problemas de Presión Arterial
☐ Cáncer (Tipo) ______________________
☐ Parálisis Cerebral
☐ Varicela __________ (Mes &Año)
☐ Fibrosis Quística
☐ Dental/Frenos ☐ si ☐ no
☐ Diabetes (Tipo: ☐ Tipo I ☐ Tipo II)
☐ Trastornos Emocionales

☐ Desmayo
☐ Pérdida de la Audición (Tipo: ☐ Audífono ☐ Implantes)
☐ Condición Cardíaca (Especifique) ______________________
☐ Dolor de Cabeza
☐ Hospitalización/Cirugía o Enfermedad (Especifique fecha & tipo) ______________________
☐ Neuro/Muscular/Ortopédico/Fractura (Especifique fecha & tipo) ______________________
☐ Hemorragia Nasal
☐ Embarazo (Fecha de Entrego)
☐ Trastorno Convulsivo
☐ Grave Accidente/Lesión (Especifique fecha & tipo) ______________________
☐ Problemas del Habla
☐ Úlcera
☐ Defecto de Visión /Usa Corrección ☐ si ☐ no

Información adicional para compartir con la enfermera:

____

If, in the judgment of any representative of the school, the above student should need immediate care and treatment as a result of any injury or sickness, I do hereby request, authorize and consent to such care and treatment as may be given said student by any doctor, trainer, nurse, or school representative, and I do hereby agree to indemnify and save harmless the doctor, the school and any school representative from any claim by any person whomsoever on account of such care and treatment of said student. I give my permission for the physicians of the above named student to release information on health problems to the Stephenville Independent School District and for the School's Nurse to consult with his/her physicians in the interest of the student's health.

Si a juicio de cualquier representante de la escuela, el estudiante ya mencionado debe necesitar atención inmediata y tratamiento como resultado de cualquier lesión o enfermedad, por la presente solicitud, autorización y consentimiento para dicha atención y tratamiento, se puede proveer al estudiante por cualquier médico, entrenador, enfermera, o representante de la escuela, y yo por la presente se compromete a indemnizar y eximir de responsabilidad al médico, la escuela y cualquier representante de la escuela de cualquier reclamo por cualquier persona quien a causa de esa atención y el tratamiento de dicho estudiante. Doy mi permiso para que los médicos del estudiante ya mencionado, compartir información sobre los problemas de salud al Distrito Independiente Escolar de Stephenville y para la Enfermera Escolar consultar con sus médicos en el interés de la salud del estudiante.

______________________ Signature of person who has Legal Custody or Guardianship

______________________ Firma de la persona que tenga custodia legal o tutela

______________ Date/Fecha

Gilbert Intermediate School

950 N. Dale
Stephenville, TX 76401
254-968-4664 FAX 254-968-8696

Principal – Mary Laigle

Assistant Principal – Jill Heupel
Counselor – Sherry Rasmuson

PEIMS Secretary–Jamie Whaley
Receptionist – Bonnie Hart

Consent for Travel to Camp Grady Spruce and Notification Regarding Liability

I hereby give my permission for my child, ______________________, to participate in the outdoor education program at Camp Grady Spruce. I understand that my child will be supervised by teachers, camp staff, and parents for three days and two nights. I give my consent and authorization for my child to participate in the program. This is also to acknowledge and agree that I waive any claim for personal injury and release the teachers, parents, and Stephenville ISD from any and all liability for injury or illness incurred at camp. I give the Stephenville ISD and camp staff permission to act for me in a reasonable manner according to its best judgment in any emergency.

I also certify that my child mentioned above has no physical or other limitations that would prevent or impede her participation at Camp Grady Spruce. I do understand that parents/guardians are solely responsible for all medical expenses due to injury or illness of my child that may be incurred as a result of participation at camp.

Parent Signature ______________________________________

Parent Name (Printed)__________________________________

Date ________________________

Liberación de Responsabilidad para el campamento de Grady Spruce

Yo por este medio le doy permiso a mi hijo(a),______________________, para que participe en la educación al aire libre del programa en el campamento de Grady Spruce. Yo entiendo que mi hijo(a) va hacer supervisada por los maestros, el personal del campamento de Grady Spruce y padres de familia por tres días y dos noches. Esta autorización renuncia, libera y absuelve a los maestros, padres de familia y el Distrito escolar independiente de Stephenville de cualquier y toda responsabilidad de lesiones o enfermedad ocurridas en el campamento. Yo le otorgo permiso al personal del campamento de actuar por mí conforme a su mejor juicio en caso de una emergencia. Yo también certifico que mi hijo(a) mencionada en esta carta no tiene ningún problema físico que impida su participación en el campamento de Grady Spruce. Yo entiendo que los padres o tutores son los únicos responsables por

TODOS los gastos médicos debido a una lesión o enfermedad por el campista mientras en el campamento.

Firme de padre o madre ____

Nombre de padre o madre____

Fecha____________________

Matemáticas examen