Queen of All Saints School
Health Records for 2020-2021

The following forms must be completed and turned in prior to the first day of school.

1. **Annual Student Health Information Form**
   - This is the light green form. This must be completed by a parent or guardian for every student in every grade, every year.

2. **Emergency Medical and Contact information sheet**
   - This is the yellow form, double-sided.. One per family. This needs to be filled out every year.

3. **Physical Examination Form that includes the Immunization records**
   - All students entering **Pre-school, Kindergarten, 3rd grade, 6th grade, and any newly enrolled students or transfer students** must have a Physical Examination record submitted that is not greater than 1 year old from the first day of school.
   - Your child's health care provider may use the enclosed Physical Examination form or may use their own office form. Please make sure the child's immunization records are included.

   ** For students entering 8th grade, we need documentation of the Tdap and Meningococcal vaccine. A physical for these students is not required unless the student is a newly enrolled student. If you have already turned in this documentation in a previous year you do not need to turn it in again. (The Tdap and Meningococcal vaccines are usually given at 11 or 12 years of age.)

4. **Emergency Medication Consent Form**
   - One form per family filled out every year. This form is consent (or refusal of consent) for administration of life saving medications (epinephrine and albuterol). Queen of All Saints has obtained these two life-saving medications to keep stocked in the event of an emergency.
   - If your child is already prescribed an Epi-Pen/ Auvi-Q or inhaler please still send those medications in with the appropriate forms to keep in the health room.
   - These Emergency Stock Medications are intended to be used in **only life-threatening** situations in a child with **unknown history** of anaphylaxis or asthma.
   - You may check the "yes" or "no" option, but either way please complete and return this form.
   -

5. **Authorization for Medication Administration in School**
   - Only some students will need this form.
   - If you have a medication (over-the -counter or prescription) that you will be sending in to be administered at school, this form needs to be completed.
   - There are two parts to this form. The top portion is the physician's order; however, the pharmacy label on a prescription medication indicating dose, frequency, and ordering doctor is also fine as a substitute. The doctor's office may also fax an order to the school office.
   - The bottom portion of the form also needs to be completed, which is the parent permission signature.
   - For asthma, severe food allergies, seizures, and diabetes please also send in any updated Action Plans.

Any questions about immunization requirements or health documents, please feel free to contact Sarah Dalton at daltons@qasstl.org.

School Year 2020-2021

Annual Student Health Information Form

Please Print:

______________________ ______________________ __________ ________ M ☐ F ☐
Student's Last Name First Birthdate Grade

Doctor: ______________________________________ Phone # ______________

Dentist: ______________________________________ Phone # ______________

Specialist: ______________________________________ Phone # ______________

History/Medical Diagnosis - Please check any that apply and return to school office

☐ ADHD ☐ ***Asthma** ☐ Autism ☐ ***Diabetes** ☐ Heart/Lung ☐ ***Seizure Disorder** date of last seizure ________

☐ ***Allergies (specify)**

Drug Allergies	Food Allergies	Insect/Bee Allergies	Other Allergies

*** Medical diagnoses that impact your child's health and safety during the school day and/or require treatment or accommodations, such as severe food allergies, asthma, etc., will need an Action/Care Plan completed by the physician.**

☐ Hearing Loss/Aids right / left ear ☐ Glasses/Contacts distance / near ☐ Anxiety

☐ Other Health Information ______________________________________

☐ Behavioral Concerns ______________________________________

☐ Concerns that might affect performance at school ______________________________________

☐ **NO KNOWN HEALTH PROBLEMS**

Please list medication given at home or school:

Medication______________ Reason______________ Dose________ Time(s)________

Medication______________ Reason______________ Dose________ Time(s)________

Medication______________ Reason______________ Dose________ Time(s)________

*** Any medications to be administered at school requires the completion of Authorization of Medication Administration in School form.**

Parent/Guardian Name (print): ______________________________

Parent/Guardian Signature: ______________________________ **Date:** ____________

PHYSICAL EXAMINATION FORM

In accordance with the recommendations of the **Saint Louis Archdiocese Health Advisory Committee**, all children are expected to have a complete physical examination upon entrance to **Pre-School, Kindergarten, 3rd Grade, 6th Grade, 9th Grade, and all newly enrolled students** who have not had a physical examination within the past twelve (12) months. The physical examination must be completed and signed by a medical doctor or physician assistant/nurse practitioner working under a collaborative practice agreement with a medical doctor.

This form is provided for the convenience of your child's physician. At the time of the examination, please have your physician complete and sign this form. It is expected that each student have this form on file at school by the first day of school.

School ______________________________ Grade ____________

Student's Name ______________________________ DOB ____________ M or F ________

Date of Examination ____________________

Height __________ Weight __________ BP __________ Pulse__________ BMI ______

General Appearance

Nutrition ________ Nose ________ Abdomen ________ Skin________ Mouth ________
Back ________ Lungs ________ Genitalia ________ Head ________ Throat ________
Extremities ______ Heart ________ Neck ________ Eyes ________ Neurologic Exam ________

Physician Comments & Recommendations – Give Details of Management of Significant Illnesses

____

____

Can Student Carry a Full Program of School Work? Yes No (circle one)
Should Physical Activity Be Restricted? Yes No
Explain____

____

Hearing Test: Type of Test ____________________ R L Both

Vision Test: Type of Test ____________________ R L Both

Physician Signature ______________________________Date________________

Print Physician Name____

Office Stamp	**PLEASE ATTACH A COPY OF THE CURRENT IMMUNIZATION RECORD**

Queen of All Saints

Emergency Medication Consent Form: School Year 2020-2021

According to Missouri State Statute Section 167.630, RSMo and 167.0635.1, RSMo schools are able to obtain and maintain an adequate supply of epinephrine pre-filled auto syringes and asthma-related rescue medications for emergency use by the employed school registered nurse licensed under chapter 335. The school registered nurse or another employee trained and supervised by the employed school registered nurse may administer these medications when they believe, based on training, that a student is having a life-threatening anaphylactic reaction or life-threatening asthma episode.

The St. Louis Archdiocese has adopted a new policy on Emergency Stock Medications. We have decided to stock Emergency Epinephrine and/or Albuterol for those students with no known history of anaphylaxis or asthma.

CONSENT

Parental approval to use standing physician ordered medications allows for efficient treatment of students emergency health issue.

_______YES _______NO I give my permission for the nurse or trained designee to administer appropriate standing physician ordered emergency medications for my child(ren):

____

Print Name DOB

____

Print Name DOB

____

Print Name DOB

____

Print Name DOB

*______________________	*__________________________	*____________
Parent/Guardian Name (print)	Parent/Guardian Signature	Date

QUEEN OF ALL SAINTS EMERGENCY MEDICAL INFORMATION 2020/21

PLEASE PRINT THE FOLLOWING INFORMATION, ONE PER FAMILY, AND RETURN TO THE SCHOOL OFFICE

FAMILY (LAST NAME/S ONLY): ____________________

HOME ADDRESS: ____________________ **Zipcode:** __________

HOME PHONE NUMBER/S: ____________________ **Public School District:** __________

PLEASE LIST THE FOLLOWING INFORMATION FOR EACH CHILD:

FIRST NAME/DOB	GR. 20/21	SIGNIFICANT MEDICAL CONDITION/S	MEDICATION/S (all home and school)	ALLERGIES(ALL) (meds, pets, foods, etc.)
1. ______ DOB ______	______	______	______	______
2. ______ DOB ______	______	______	______	______
3. ______ DOB ______	______	______	______	______
4. ______ DOB ______	______	______	______	______
5. ______ DOB ______	______	______	______	______

FATHER'S NAME: ____________________
EMPLOYER: ____________________
WORK #: ____________________
E-MAIL: ____________________
CELL: ____________________

MOTHER'S NAME ____________________
EMPLOYER: ____________________
WORK #: ____________________
E-MAIL: ____________________
CELL: ____________________

QUEEN OF ALL SAINTS EMERGENCY MEDICAL INFORMATION 2020-2021

PHYSICIAN'S NAME: ______________________________ **PHONE:** ______________

DENTIST'S NAME: ______________________________ **PHONE:** ______________

HOSPITAL OF CHOICE: ______________________________

(If necessary and in the best interest of our child)

EMERGENCY CONTACTS: Designated person(s) to pick up child/ren if parent cannot be notified or the event of disaster (tornado, earthquake, fire, etc.) or illness. No child will be allowed to leave with another person, even a relative or babysitter, unless we have written permission to that effect. Please list the names of person(s) with whom your child/ren may be released. Parents will always be contacted first unless otherwise indicated. Please list alternate contacts below in order of importance.

NAME: ____________________ **PHONE:** ______________ **RELATIONSHIP:** ____________

NAME: ____________________ **PHONE:** ______________ **RELATIONSHIP:** ____________

NAME: ____________________ **PHONE:** ______________ **RELATIONSHIP:** ____________

NAME: ____________________ **PHONE:** ______________ **RELATIONSHIP:** ____________

In the event any of the children incurs bodily injury or serious illness, we request the school contact us by phone at the numbers listed on this form. If we can't be reasonably contacted and immediate first aid/and or medical or surgical treatment appears necessary, with respect to such illness or injury, then we hereby authorize any representative(s) of the school to act on our behalf to render first aid and/or arrange for our child's transportation and admission to hospital or medical clinic necessary and in the best interest of our child. We hereby authorize and consent to such first aid and/or medical or surgical treatment and we further indemnify and save harmless the school and agents, and said physicians for any claims or losses whatsoever of the undersigned and/or of our child arising out of the foregoing.

Parent/Legal Guardian signature: ______________________ **Date:** ______________

APPENDIX 1

Authorization for Medication Administration in School

Student Name:________________________________ DOB: ____________Grade:__________

TO BE COMPLETED BY PRESCRIBING PHYSICIAN

Medication: Prescription ☐ Over the Counter ☐

Name of Medication	Dosage	Route	Time(s) to Be Taken
______________	______	______	______

Diagnosis or reason for medication: ______________________________

If given PRN, specify the **minimum** length of time between doses:______________________

Possible medication side effects:______________________________

Restrictions or Special Instructions:______________________________

I request and authorize the above-named student be administered the above medication in accordance with the instructions indicated above from _______ (date) to _______ (date) (not to exceed current school year).

______________________ Date

______________________ Physician Name (please print)

______________________ Telephone Number

______________________ Physician's Signature

OFFICE STAMP:

TO BE COMPLETED BY THE PARENT / GUARDIAN

☐ I give my permission for this medication to be administered to my child at school. The school has my permission to call the physician with any questions regarding the medication.

☐ I understand and acknowledge that any medication administered to my child during school will more than likely not be administered by a registered nurse or other medical professional. In consideration of the school administering medication to my child pursuant to this authorization, I hereby release and hold harmless the school, the Archdiocese of St. Louis, and their employees, agents or representative, from any liability that may arise from administering medication to my child.

☐ All medication supplied must be brought to school in its **original container** with instructions as noted above by the physician.

______________________ Date

______________________ Parent/Guardian Name (Print)

______________________ Parent/Guardian Signature

Please ask the pharmacist for an extra-labeled bottle for school. Thank you!