Queen of All Saints School
Health Records for 2023-2024

The following forms must be completed and turned in prior to August 1, 2023.

1. **Annual Student Health Information Form**
   - This is the pink 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 double -sided green form. 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 around 12 years of age.)

4. **Emergency Medication Consent Form**
   - One form per family is filled out every year. This form is consent (or refusal of consent) for administration of life saving medications (epinephrine and albuterol) 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 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. Action Plans are good for only one year.

2023-2024

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:** _____

QUEEN OF ALL SAINTS EMERGENCY MEDICAL INFORMATION 2023/24

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. 23/24	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 2023-2024

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:** _____

PHYSICAL EXAMINATION FORM

In accordance with the recommendations of the **Archdiocese of Saint Louis 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 licensed doctor of medicine (MD), doctor of osteopathy (DO), or a physician's assistant (PA), or nurse practitioner (NP), working under a collaborative practice agreement with a licensed physician.

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 a physical 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 _____ BMI _____ BP _____ Pulse_____

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_____

	PLEASE ATTACH A COPY OF THE CURRENT IMMUNIZATION RECORD

Office Stamp

Queen of All Saints

Emergency Medication Consent Form: School Year 2023-2024

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

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!