



SAHUARITA UNIFIED SCHOOL DISTRICT #30

SAHUARITA HIGH SCHOOL
SAHUARITA MIDDLE SCHOOL
SAHUARITA PRIMARY SCHOOL
ANZA TRAIL SCHOOL
EARLY CHILDHOOD CENTER

WALDEN GROVE HIGH SCHOOL
SAHUARITA INTERMEDIATE SCHOOL
SOPORI ELEMENTARY SCHOOL
COPPER VIEW ELEMENTARY SCHOOL



SCHOOL HEALTH SERVICES

ANNUAL STUDENT MEDICAL INFORMATION UPDATE FORM

All students must have completed form on file upon New Enrollment, and entry into Kinder, 3rd Grade, 6th Grade, and 9th Grade, and upon request to update student health records. Additionally, parents are strongly encouraged to enroll each of their students in www.caredox.com and update information annually. Information will be stored in Student Health Records and will be confidential to the greatest extent allowable by law.

Student Last Name Student First Name Date of Birth Grade

Parent E-Mail (Step) Mother/Guardian Daytime Phone (Step) Father/Guardian Daytime Phone

Does your child have any of the following Allergies or Health Conditions (Please speak with the health office regarding any health conditions and notify classroom teachers):

- YES NO Asthma: Has moderate to severe Asthma
YES NO Diabetes: Type I Type II
YES NO Seizure Disorder Febrile
YES NO Heart Condition Pacemaker Defibrillator
YES NO Bleeding Disorder
YES NO Has Epi-Pen for Anaphylactic Allergy
YES NO Food Allergies (Please List):
YES NO Sting or Environmental Allergies (Please List):
YES NO Medication Allergies (Please List):
YES NO Other Medical Condition (Please List):
YES NO Take medications regularly? (Please List):
YES NO Kidney Disease
YES NO Gastrointestinal Disorder
YES NO ADHD
YES NO Wears Glasses/Contacts Legally Blind
YES NO Known Permanent Hearing Loss
YES NO Wears Hearing Aid(s)/Implant

MEDICATION POLICY: Sahuarita Unified School District is a "drug free" zone. Students MAY NOT transport medications to/from school or have medications (prescription and/or non-prescription) in their possession at anytime. If your student requires medications at school or you have any questions regarding our medication policy, please contact your school health office. Parents may find additional information regarding Medication Procedures online at https://susd30.us/district-services/health/

STANDING ORDER MEDICATIONS: Sahuarita Unified School District has written "standing physician orders" to for the School Nurse or Health Assistant to administer the following medications: TYLENOL, BENADRYL, and TOPICAL ANTIBIOTICS such as BACITRACIN OINTMENT to students with written permission by the parent (give below), students in grades K-8 will require additional verbal parent consent prior to each dose administered. Standing Order Medications are only to be used as a last resort after other non-medication treatments are provided. Regular use of these medications WILL require additional written physician's orders from the students personal medical care provider.

Please Check (✓) and initial the appropriate boxes.

I DO I DO NOT give permission for the School Nurse, Health Aide, or other personnel trained by the School Nurse to administer the above noted medications, in a given situation.

STUDENT MEDICAL EMERGENCIES POLICY: In case of an emergency, the nurse, health assistant, principal, or an authorized designee SHALL call for EMERGENCY MEDICAL SERVICES. Every attempt will be made to contact parents ASAP. In the event a student experiences what appears to be respiratory distress, trained school personnel may administer an ALBUTEROL RESCUE INHALER and call 9-1-1 as needed. In the event a student experiences what appears to be an anaphylactic allergic reaction, trained school personnel may administer EPINEPHRINE and call 9-1-1. Albuterol and Epinephrine use for emergencies is subject to medication availability. Students diagnosed with Asthma or Anaphylactic Allergies must provide their own personal supply to ensure the medication is always available to them in the event of an emergency.

The individual patient (parent/guardian) will be responsible for incurred costs of transportation and medical service.

Please Check (✓) and initial the appropriate boxes.

I DO I DO NOT give consent for emergency treatment of my child by a physician in the event of an emergency occur and a parent/guardian and emergency contact person cannot be reached.

Parent's Choice of hospital: 1) 2)

Child's Doctor: Telephone: Insurance Provider:

I certify that the information on this page is accurate and complete to the best of my knowledge.

Parent Signature: Date:

STAFF: Please Print on HOT PINK paper! This form shall NOT be copied and should be sent directly to health office. Do not place in CUM