Instructions for Nurse's Packet

1. You must submit a new copy of your student's vaccination records every year during orientation.
2. If your student has not yet been added to Immtrac or you have opted out of the immunization Texas registry, you must sign appropriate documentation and submit. (IMMTRAC Form)
3. Please fill out only the top portion of the Vision, Hearing and if applicable Spinal Screening forms, which only includes student name, grade, date of birth, address. (DO NOT ENTER any height, weight or other medical information, Thank you).
4. Please read, sign and date the Texas Health Guidelines document. Please keep the top portion of the document and make sure to submit the signature part.
5. Please read, initial all lines on the left and sign to agree or disagree to give medical consent to HSAGP or emergency personnel. A copy of this signed document may be requested to the nurse.
6. If your student will be keeping and taking medications at school please submit a completed Medication Form.

Instrucciones para el paquete de enfermeria

1. Deben presentar una nueva copia de los registros de vacunación de su hijo cada año durante la orientación.
2. Si su estudiante todavía no se ha agregado a Immtrac o ha optado por no registrar en el systema de inmunización de Texas, usted debe firmar documentación apropiada y presentar. (Formulario IMMTRAC)
3. Por favor llene sólo la parte superior de la visión, audición y si aplicable espinal formas de revision, que sólo incluye el nombre del alumno, grado, fecha de nacimiento, dirección. (No ingrese cualquier altura, peso u otra información médica, gracias).
4. Por favor, lea, firme y feche el documento Directrices de salud de Texas. Por favor, mantenga la parte superior del documento y asegúrese de presentar la parte de la firma.
5. Lea, y firme con sus iniciales todas las líneas a la izquierda y firme de acuerdo o en desacuerdo para dar consentimiento médico para HSAGP o el personal de emergencia. Puede solicitar una copia de este documento firmado a la enfermera.
6. Si su estudiante tomara medicamento en la escuela o mantendra medicamento disponible en la escula, debe entregar un forma de medicamento con todas las areas firmadas y completa.

Thank you, (Gracias,)

Itczel Gonzalez

Nurse (Enfermera)

TEXAS DEPARTMENT OF STATE HEALTH SERVICES
IMMUNIZATION REGISTRY (ImmTrac)
MINOR CONSENT FORM

ImmTrac
Texas Immunization Registry

(Please print clearly)

For Clinic/Office Use

Child's Last Name

Child's First Name

Child's Middle Name

Child's Date of Birth / / *__Children under 18 years only.__

Child's Gender: ☐ **Male** ☐ **Female**

Child's Address

Apartment #

Telephone

City

State

Zip Code

County

Mother's First Name

Mother's Maiden Name

ImmTrac, the Texas immunization registry, is a free service of the Texas Department of State Health Services (DSHS). The immunization registry is a secure and confidential service that consolidates and stores your child's (under 18 years of age) immunization records. With your consent, your child's immunization information will be included in ImmTrac. Doctors, public health departments, schools and other authorized professionals can access your child's immunization history to ensure that important vaccines are not missed.

The Texas Department of State Health Services encourages your voluntary participation in the Texas immunization registry.

Consent for Registration of Child and Release of Immunization Records to Authorized Entities

I understand that, by granting the consent below, I am authorizing release of the child's immunization information to DSHS and I further understand that DSHS will include this information in the state's central immunization registry ("ImmTrac"). Once in ImmTrac, the child's immunization information may by law be accessed by:

- a public health district or local health department, for public health purposes within their areas of jurisdiction;
- a physician, or other health-care provider legally authorized to administer vaccines, for treating the child as a patient;
- a state agency having legal custody of the child;
- a Texas school or child-care facility in which the child is enrolled;
- a payor, currently authorized by the Texas Department of Insurance to operate in Texas, regarding coverage for the child.

I understand that I may withdraw this consent to include information on my child in the ImmTrac Registry and my consent to release information from the Registry at any time by written communication to the Texas Department of State Health Services, ImmTrac Group – MC 1946, P.O. Box 149347, Austin, Texas 78714-9347.

By my signature below, I GRANT consent for registration. I wish to INCLUDE my child's information in the Texas immunization registry.

Parent, legal guardian or managing conservator: _____
Printed Name

_____ _____
Date **Signature**

Privacy Notification: With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See **http://www.dshs.state.tx.us** for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003 and 559.004)

Upon completion, please fax or mail form to the DSHS ImmTrac Group or a registered Health-care provider.

Questions? (800) 252-9152 • (512) 776-7284 • Fax: (866) 624-0180 • www.ImmTrac.com
Texas Department of State Health Services • ImmTrac Group – MC 1946 • P.O. Box 149347 • Austin, TX 78714-9347

Stock No. C-7
Revised 05/18/2012

TEXAS Department of State Health Services

*__PROVIDERS REGISTERED WITH ImmTrac__ – Please enter client information in ImmTrac and **affirm** that consent has been granted. **DO NOT fax to ImmTrac. Retain this form in your client's record.***

DEPARTAMENTO ESTATAL DE SERVICIOS DE SALUD DE TEXAS
REGISTRO DE INMUNIZACIÓN (ImmTrac)
FORMULARIO DE CONSENTIMIENTO PARA MENORES

ImmTrac
Texas Immunization Registry

For Clinic/Office Use

(Favor de escribir claramente con letra de molde)

Apellido del Niño(a)

Nombre del Niño(a)

Segundo Nombre del Niño(a)

/ / ***Solamente niños menores de 18 años.**

Fecha de Nacimiento del Niño(a)

Género: ☐ **Masculino** ☐ **Femenino**

Dirección del Niño(a), Calle

Apartamento #

Teléfono

Ciudad

Estado

Código Postal

Municipio

Nombre de la Madre

Apellido de Soltera de la Madre

ImmTrac, el registro de inmunización de Texas, es un servicio gratis que proporciona el Departamento Estatal de Servicios de Salud de Texas (DSHS). El registro de inmunización es un servicio seguro y confidencial que consolida y guarda el récord de inmunizaciones de su niño(a) (menor de 18 años de edad). Con su consentimiento, la información de la inmunización de su niño(a) será incluida en ImmTrac. Los doctores, departamentos de salud pública, escuelas y otros profesionales autorizados pueden tener acceso al historial de inmunización de su niño(a) para asegurar que las vacunas importantes no le falten.

El Departamento Estatal de Servicios de Salud le anima a participar voluntariamente en el registro de inmunización de Texas.

Consentimiento Para Registrar al Menor y Dar a Conocer los Documentos de Inmunización a las Entidades Autorizadas

Entiendo que, con mi consentimiento a continuación, autorizo que se dé a conocer la información de inmunización del menor al DSHS, y además entiendo que el DSHS incluirá esta información en el registro central de inmunización del estado ("ImmTrac"). Una vez que la información del menor esté en ImmTrac, por ley la puede acceder:

- el distrito de salud pública o el departamento de salud local, para propósitos de salud pública dentro de sus áreas de jurisdicción;
- el médico, o algún otro médico o proveedor de atención de salud legalmente autorizado para administrar vacunas, en el tratamiento del menor como paciente;
- la agencia estatal que tenga la custodia legal del menor;
- la escuela o la guardería de Texas en que el menor esté inscrito;
- el pagador, actualmente autorizado por el Departamento del Seguro de Texas para operar en Texas, con respecto a la cobertura del menor.

Entiendo que puedo retirar este consentimiento para incluir información sobre el menor en el Registro de ImmTrac y mi consentimiento para dar a conocer la información del registro en cualquier momento mediante comunicación escrita a Texas Department of State Health Services, ImmTrac Group – MC 1946, P.O. Box 149347, Austin, Texas 78714-9347.

Al firmar abajo, YO AUTORIZO el consentimiento para registrarlo. Deseo INCLUIR la información de mi niño(a) en el registro de inmunización de Texas.

Alguno de los padres, tutor legal o administrador de bienes: _____

Escriba con letra de molde

Fecha _____ **Firma** _____

Notificación Sobre Privacidad: Tan solo por unas cuantas excepciones, usted tiene el derecho de solicitar y de ser informado sobre la información que el Estado de Texas reúne sobre usted. A usted se le debe conceder el derecho de recibir y revisar la información al requerirla. Usted también tiene el derecho de pedir que la agencia estatal corrija cualquier información que se ha determinado sea incorrecta. Diríjase a **http://www.dshs.state.tx.us** para más información sobre la Notificación sobre privacidad. (Referencia: *Government Code*, sección 552.021, 552.023, 559.003 y 559.004)

Al rellenarlo, mándelo por fax o correo postal al Grupo ImmTrac del DSHS o a un proveedor de salud inscrito.

¿Tiene preguntas? (800) 252-9152 • (512) 776-7284 • Fax: (866) 624-0180 • www.ImmTrac.com
Texas Department of State Health Services • ImmTrac Group – MC 1946 • P.O. Box 149347 • Austin, TX 78714-9347

Stock No. C-7
Revised 05/18/2012

TEXAS Department of State Health Services

PROVIDERS REGISTERED WITH ImmTrac** – Please enter client information in ImmTrac and **affirm** that consent has been granted. **DO NOT fax to ImmTrac. Retain this form in your client's record.

HARMONY SCIENCE ACADEMY

◆1102 NW 7th Street, Grand Prairie, TX 75050 ◆ Tel: 972.642.9911 ◆ Fax: 972.642.9922
◆ Web: www.hsagp.org

TO DECLINE IMMTRAC
DO NOT SIGN IF YOUR STUDENT IS ON IMMTRAC.

I, _____ parent of _____, which is to enroll in _____ grade for the 2014-2015 school year, would prefer to decline the use of ImmTrac at this time for my child. I understand this is the system used by HSAGP to keep immunization records in order and maintained. I further understand that it is my choice to decline. I am aware that this is a free service, which helps keep the records of my child on a Texas registry in which for some reason I lose or misplace my paper documents, my child's vaccination record can easily be recovered through the school, university, or Texas Department of Health office.

Reason for decline:

_____
_____
_____
_____
_____

Date of decline: _____.

Parent signature: _____

Parent printed name: _____

For Office (Nurse) Use Only:

____ Student is enrolled
____ Student withdrawal
____ Student has vaccination exemption through the state of Texas

Vaccination verification on: _____ by _____

Student approved for enrollment_____ not approved for enrollment_____

School Nurse Signature: _____

DEPARTMENT OF STATE HEALTH SERVICES
CERTIFICATE OF RECORD FOR
VISION SCREEN AND/OR EYE EXAMINATION

ATTENTION PARENT: The Vision and Hearing Screening Program requires that every child have an eye examination or an approved vision screening test prior to or within 120 days after entry into a Texas licensed child-care facility or school.

SCHOOL NAME HSA-GP CITY Grand Prairie, TX COUNTY Dallas
CHILD'S NAME _____ BIRTHDATE _____ AGE _____
PARENT'S NAME _____ TELEPHONE NO. _____
ADDRESS _____ CITY _____ ZIP _____

The tests conducted to evaluate your child's vision are screens; they are not diagnostic. This means that if the child fails a screen, it is necessary for your child to be evaluated by a vision specialist, an ophthalmologist or an optometrist, to determine whether there is a vision problem. It also means that on some occasions a vision problem may exist that the screens will not identify.

**** VISION SCREENER REPORT ****

DISTANCE ACUITY SCREEN:

SCREENER: _____

1ST SCREEN: DATE _____	2nd SCREEN: DATE _____	**COMMENTS/OBSERVATIONS:**
With Correction: □ Yes □ No	With Correction: □ Yes □ No	
Chart Used:	Chart Used:	
Letter □ Right Eye 20/	Letter □ Right Eye 20/	
"E" □ Left Eye 20/	"E" □ Left Eye 20/	
H:O:T:V	H:O:T:V	
Machine □ PASS □ FAIL	Machine □ PASS □ FAIL	

HIRSCHBERG CORNEAL LIGHT REFLEX TEST	COVER AND UNCOVER	
□ Light reflection is centered or slightly toward the nose the same distance in each eye.	NEAR: 12-13 inches	FAR: 10 – 20 Feet
□ Light reflection is not centered nor slightly toward the nose the same distance in each eye	□ No Eye Movement	UNABLE TO ASSESS
	□ Eye Movement	
□ PASS □ FAIL	□ PASS □ FAIL	□ PASS □ FAIL

REFERRAL TO AN EYE CARE SPECIALIST (OPHTHALMOLOGIST OR OPTOMETRIST) DUE TO:

□ Distance Acuity Test
□ Hirschberg Corneal Light Reflex Test
□ Cover and Uncover Test
□ Observable Signs or Symptoms _____ (describe)
□ Parent/Doctor Request
□ Other: _____
□ UNSCREENABLE

DATE OF FINAL SCREEN: NAME OF SCREENER:

***** WAIVER OF REFERRAL *****

My child _____ is being seen by an eye care specialist,

_____ (doctor's name), for the problem(s) indicated.

_____ _____
Parent's Signature Date

Revised 9/2011 M-60

STUDENT'S NAME: _____ BIRTH DATE: _____
SCHOOL: HSA-GP GRADE: ____ TEACHER: _____

THE INFORMATION ENTERED ON THIS FORM IS A RECORD OF SCREENING RESULTS AND IS NOT TO BE USED FOR DIAGNOSTIC PURPOSES.

****

SWEEP-CHECK SCREENING

1. Instruct and condition each child appropriately for age/grade.
2. Screen 3 frequencies @ **25 dB;** begin screening @ 1000 Hz.
3. Identify responses with a **"+"**; identifying no response with a **"-"**.
4. Sequence of tone presentations is numbered 1-3 below.

	EAR	1 1000 Hz	2 2000 Hz	3 4000 Hz	RESULTS
First Screen	**R**				_____ **Pass**
Date:	**L**				_____**Rescreen w/Sweep**

COMMENTS: _____

Screener: _____ Children failing to respond to **ONE** (of the three) frequencies in **EITHER EAR** should be re -screened with another Sweep-Check within 3 to 4 weeks. (Signs or symptoms alone would be sufficient for referral.) Failure of **ONE** frequency in either ear on the second sweep check screen requires a referral or an **Extended Recheck**. If a failure of one frequency occurs when performing the extended recheck, a referral is required.

****

	EAR	1 1000 Hz	2 2000 Hz	3 4000 Hz	RESULTS
Second Screen	**R**				_____ **Pass**
Date:	**L**				_____ **Fail**

COMMENTS: _____

Screener: _____

****

EXTENDED RECHECK RESULTS

For each of the three frequencies listed, starting at **40 dB,** record the lowest level in decibels (dB) at which the child responds. Record the findings for both the right and left ears. A child should be referred to an appropriately licensed professional if any one of the three frequencies are recorded as greater than **25 dB** in either ear.

	EAR	1 1000 Hz	2 2000 Hz	3 4000 Hz	RESULTS
	R	**dB**	**dB**	**dB**	_____ **Pass**
Date:	**L**	**dB**	**dB**	**dB**	_____ **Fail**

COMMENTS: _____

Screener: _____

TEXAS HEALTH GUIDELINES

When to keep you child home from school due to an illness:

At times it can be difficult to decide whether to send your children to school when they don't feel well. Illness is never convenient and as busy parents, we understand work schedules, childcare arrangements, transportation and other family matters are to be considered in that decision, and we understand, you want what is best for your child's health.

Good attendance is extremely important at Harmony Science Academy for your child's success at school! Unfortunately, there are times when it is out of our control and your child may feel sick.

Texas law guidelines require exclusion for contagious diseases that could be spread at school, and must be enforced for the prevention of further spread to other students and for safety of all our students and staff. In accordance to Texas State Regulations Infection Control, if a parent fails to pick up their child from school due to an illness within 1 hour(s) after parent/guardian has been advised, the school is obligated to call proper authorities.

If your child/children have the following symptoms, they should stay home and not come to school until these symptoms have been gone for at least 24 hours without the help of medication, or until your doctor sends a note that states the condition is no longer contagious and it is OK for your child to come back to school.

FEVER - If a fever of over 100 degrees Fahrenheit is present, DO NOT send him or her to school. Please do not send them even for just a short time in the morning to obtain "perfect attendance." Although giving fever medication may reduce the fever, it does not take care of the illness causing the fever, therefore coming to school sick (and possibly contagious) not only exposes other children to the illness, but also delays your child's healing time. Once the medicine wears off and the fever returns and your child must be picked up, and valuable healing time has been lost. Children must be fever-free for 24 hours, without the use of medicine, before returning to school.

VOMITING/DIARRHEA - If vomiting or diarrhea happen more than once that day, or if they are associated with fever, you must keep your child home until they have been free of symptoms for 24 hours. Even if these things happen only one time before school starts, and your child feels better immediately afterwards, it is important to watch for a few hours to see if it happens again before sending him or her on to class.

SKIN RASHES - if the rash has any fluid or pus coming from it, your child must remain out of school until the rash has been treated and a doctor's note states it is ok to

return to school, or until the rash is gone, dried, or scabbed over with no new spots. Anytime a rash is accompanied by a fever, the child may not come to school until that fever is gone for 24 hours without medication. Sometimes a rash can be a sign of a contagious disease such as chickenpox. Other times rashes are not contagious but are uncomfortable and irritated from contact with something causing an allergic reaction, which in that case, please consider comfort measures such as an antihistamine in accordance with the district policy for medication administration at school and discussing possible treatment with your doctor and a care plan with the school nurse.

RED EYES, ESPECIALLY IF THERE IS ALSO DRAINAGE OR CRUSTING AROUND THE EYE - can often mean your child may have conjunctivitis (pink-eye). Not all pink-eye is contagious, but sometimes it can be allergies or other irritations that are causing the red color, but until we know for sure (which means we must have a doctor's note stating the condition is not contagious, or until the redness and drainage are completely gone), your child must remain out of school.

PEDICULOSIS (HEAD LICE) OR SCABIES - these are small insects that cause skin conditions and are uncomfortable and itchy, and could become infected with all the scratching. Check with the school nurse to get information on treatment and when your child may return to school if those conditions are present. We do not advocate expensive treatments or toxic chemicals!

Other medical conditions:

If your child has other symptoms such as headaches, cramps, sore throat, cough and/or thick mucus, which do not require them to be out of school but will make them uncomfortable during class, please discuss the use of over-the-counter (OTC) or prescription medications with your child's doctor. Remember to follow the district requirements for giving medications at school. Call the school nurse if you are not sure about those requirements.

If your child has a chronic medical condition that requires a nursing care plan, please schedule a meeting with the school nurse to make sure everything is properly set up for your child's needs though out the school year.

If you feel you still have questions and concerns, please feel free to contact me 972-642-9911.

Thank you

Itczel Gonzalez
Nurse

TEXAS PAUTAS DE SALUD

Cuando mantener a su niño(a) en casa, debido a una enfermedad:

A veces puede ser difícil decidir si enviar a sus hijos a la escuela, cuando no se sienten bien. La enfermedad nunca es conveniente para padres ocupados, ya que compremos los horarios de trabajo, servicios de guardería, transporte y otros asuntos familiares deben ser considerados en dicha decisión, y entendemos, que desea lo mejor para la salud de su hijo. La buena asistencia es extremadamente importante en Harmony Science Academy para el éxito de su hijo(a) en la escuela! Por desgracia, hay veces en que está fuera de nuestro control y que su hijo puede sentirse enfermo.

Directrices de la ley de Texas, requieren la exclusión de las enfermedades contagiosas que podrían ser repartidas en la escuela, y deben hacerse cumplir para la prevención de la propagación a otros estudiantes y seguridad para los estudiantes y personal. De acuerdo a las Regulaciones del departamento de Texas Control de Infecciones, si un padre no puede recoger a sus hijos de la escuela debido a una enfermedad dentro de 1 hora (s) después del padre / tutor ha sido advertido, la escuela tiene la obligación de llamar a las autoridades correspondientes.

Si su hijo / hijos tienen los siguientes síntomas, debe(n) quedarse en casa y no ir a la escuela hasta que estos síntomas han desaparecido por lo menos 24 horas sin la ayuda de medicamentos, o hasta que el médico envíe una nota que indique la condición ya no es contagiosa y que está bien que su hijo regrese a la escuela.

FIEBRE –

Si una fiebre de más de 100 grados Fahrenheit está presente, NO mande a la escuela a su estudiante. Por favor, no lo(a) envie aunque solo sea por un corto tiempo en la mañana para obtener "asistencia perfecta". Aunque la administración de medicamentos de fiebre puede reducir la fiebre es temporal, y no cura la enfermedad que causa la fiebre, por lo tanto, ir a la escuela no sólo expone a los demás niños a la enfermedad, sino que también retrasa el tiempo de curación de su hijo(y posiblemente contagiosa). Una vez que el medicamento haya pasado y las declaraciones de la fiebre y su hijo deben ser recogidos y valioso tiempo de curación se ha perdido. Los niños deben estar sin fiebre por 24 horas, sin el uso de la medicina, antes de regresar a la escuela.

Vómitos / diarrea –

Si el vómito o la diarrea ocurren más de una vez ese día, o si se asocian con fiebre, se debe mantener al niño en casa hasta que hayan estado libre de síntomas durante 24 horas. Incluso si estas cosas suceden sólo una vez antes de que empiecen las clases, y que su hijo se siente mejor inmediatamente después, es importante estar pendiente de un par de horas para ver si sucede otra vez antes de que él o ella envía a clase.

Erupciones en la piel –
Si la erupción tiene cualquier líquido o pus, su hijo debe permanecer fuera de la escuela hasta que la erupción ha sido tratado y una nota del doctor afirma que está bien para volver a la escuela, o hasta que la erupción se ha ido, se seca, o costras sin nuevos puntos. Cada vez que una erupción se acompaña de fiebre, el niño no puede venir a la escuela hasta que la fiebre haya desaparecido por 24 horas sin medicación. A veces una erupción puede ser un signo de una enfermedad contagiosa como la varicela. Otras veces las erupciones no son contagiosas, pero se sienten incómodos e irritados por el contacto con algo que causa una reacción alérgica, que en ese caso, por favor, considere medidas de confort, como un antihistamínico de acuerdo con la política del distrito para la administración de medicamentos en la escuela y discutir el posible tratamiento con su médico y un plan de atención con la enfermera de la escuela.

OJOS ROJOS,
Especialmente si también hay drenaje o formación de costras alrededor del ojo - a menudo puede significar que su niño puede tener conjuntivitis (ojo rosado). No todos-conjuntivitis es contagiosa, pero a veces puede ser las alergias u otras irritaciones que causan el color rojo, pero hasta que no sepamos a ciencia cierta (que significa que debemos tener una nota del médico que indique la condición no es contagiosa, o hasta que el enrojecimiento y el drenaje están completamente ido), su hijo debe permanecer fuera de la escuela.

Pediculosis (piojos) O SARNA - estos son pequeños insectos que causan enfermedades de la piel y no se sienten cómodos y con comezón, y podría llegar a infectarse con todo el rascado. Consulte con la enfermera de la escuela para obtener información sobre el tratamiento y cuando su hijo puede regresar a la escuela si estas condiciones están presentes. No abogamos por costosos tratamientos o productos químicos tóxicos! Otras condiciones médicas: Si su hijo tiene otros síntomas tales como dolores de cabeza, calambres, dolor de garganta, tos y / o moco espeso, que no requieren de ellos para estar fuera de la escuela, pero le harán sentir incómodos durante la clase, por favor discutir el uso de medicamentos sin receta(OTC) o medicamentos con receta con el médico de su hijo. Recuerde seguir los requisitos del distrito para administrar medicamentos en la escuela. Llame a la enfermera de la escuela si no está seguro acerca de esos requisitos. Si su hijo tiene una enfermedad crónica que requiere un plan de cuidados de enfermería, por favor programe una reunión con la enfermera de la escuela para asegurarse de que todo está configurado correctamente para las necesidades de su hijo aunque fuera el año escolar. Si usted se siente todavía tienen preguntas y preocupaciones, por favor no dude en ponerse en contacto conmigo 972-642-9911.

Gracias

Itczel González
Enfermera

TEXAS HEALTH GUIDELINES

Student Name: _____ Grade:_____

I, _____(parent/guardian name), agree, acknowledge and understand the Texas Law Health Guidelines provided to me by Harmony Science Academy-Grand Prairie, Texas and will abide and follow the regulations set for the protection of my child/children, his or her fellow pears and staff to the best of my ability. In the event my child is to get ill, I understand it is my responsibility as the parent/ guardian to contact the attendance office or school nurse. I also understand that if called by the school nurse or office personnel to pick up my child due to illness, according to Texas State Infection Control I will have 1 hour for pick up my child, and understand failure to pick my child/children from school Harmony Science Academy-Grand Prairie will have no other choice but to a call to proper authorities per Texas State Regulations Infection Control.

_____ _____
Parent/ Guardian Signature Date

_____ _____
Parent/ Guardian Signature Date

_____ _____
Parent/ Guardian Signature Date

TEXAS PAUTAS DE SALUD

Nombre del Estudiante: _____ Grado: _____

Yo, _____ (nombre del padre / tutor), de acuerdo, reconozco y entiendo las guías de salud ley de Texas proporcionados a mí por Harmony Science Academy-Grand Prairie, Texas y acataré y seguir las normas establecidas para la protección de mi hijo / hijos, su o sus compañeros de peras y personal a lo mejor de mi capacidad. En el caso de mi hijo es de enfermar, entiendo que es mi responsabilidad como padre / tutor para ponerse en contacto con la oficina de asistencia o enfermera de la escuela. También entiendo que si es llamado por el personal de enfermería de la escuela o la oficina para recoger a mi hijo debido a una enfermedad, de acuerdo con el Control de Infecciones del Estado de Texas voy a tener de 1 hora para recoger a mi hijo, y entender el fracaso a recoger a mi hijo / hijos de la escuela Armonía Academia de Ciencias-Grand Prairie no tendrá otra opción más que una llamada a las autoridades correspondientes por los Reglamentos del Estado de Texas control de Infecciones.

_____ _____
Padre / Tutor Fecha

_____ _____
Padre / Tutor Fecha

_____ _____
Padre / Tutor Fecha

HARMONY SCIENCE ACADEMY

◆1102 NW 7th Street, Grand Prairie, TX 75050 ◆ Tel: 972.642.9911 ◆ Fax: 972.642.9922
◆ Web: www.hsagp.org

Medical Consent Form

Student: _____ **DOB:** _____ **Grade**: _____

Parent Name: _____ Phone: _____

Address: _____ City_____ Zip _____

Insurance Provider: _____ Policy Number: _____

Phone number: _____ Group Number: _____

(_____) It is understood that this authorization is given in advance of any specific treatment, care or medication that may be given by the school nurse of HSAGP or health assistant of HSAGP to my child. I further understand that the medication must be provided by me, the parent or guardian. (***All prescribed medication need to have a prescription by a Physician and forms signed to administer medication according to orders prescribed.***)

(_____) I hereby consent and authorize HSAGP school nurse, HSAGP health assistant to administer the following over-the-counter medications when necessary and for the welfare of my child. I further understand that I must provide the medication to be administered in its original package or container. ***(OTC medication given over 3 consecutive days will need to have a Prescription by an authorized Physician.)***

( ) Ibuprofen ( ) Acetaminophen ( ) Triple Anti-biotic Ointment

( ) Benadryl ( ) Topical Hydrocortisone ( ) Caladryl (topical analgesic/ anti-itch)

( ) Mouthwash/toothpaste ( ) Benzocaine(oral pain relief) ( ) Menthol(cough drop)

( )Other(s)_____

(_____) I understand that in the event my student is out on a field trip, the leading teacher/administrator/adult chaperone will have my students prescribed medication in the absence of the nurse. As well as I the parent or guardian will be responsible for providing the teacher/administrator or adult chaperone with a signed permission form including my medical insurance information.

(_____) In the event I am unable to be reached and my child is in need of emergency medical assistance, I hereby consent for any medical care and the administration of medication to be given to my child in my absence for the welfare of my child by emergency medical personnel, the school nurse of HSAGP or health assistant of HSAGP. In addition I understand that a copy of this document will be given to emergency personnel. I request for emergency medical services to transport my child to: ***Closest emergency hospital or The hospital of my choice***: _____.

HARMONY SCIENCE ACADEMY

◆1102 NW 7th Street, Grand Prairie, TX 75050 ◆ Tel: 972.642.9911 ◆ Fax: 972.642.9922
◆ Web: www.hsagp.org

(_____) I, the parent or guardian, authorize in advance of any specific treatment, care or medication to be given by the hospital, clinic or physician in the emergency setting.

List Allergies to Food or Medications: _____

My child suffers from Asthma: No _____ Yes _____ Type of Medication: _____

My child suffers from ADHD: Yes____ No ____ Type of Medication: _____

My child suffers from: _____ Type of Medication:_____

Will any medication be kept with the school nurse for your child? N/A ___ No ____ Yes____

Please add special instructions: _____

_____

_____

I, _____ parent or legal guardian of

_____ with date of birth _____ do hereby consent to the above:

School Year

_____Parent Signature: _____ Date: _____

_____Parent Signature: _____ Date: _____

_____Parent Signature: _____ Date: _____

_____Parent Signature: _____ Date: _____

I ***reject all of the above***. ***No treatment*** should be given to my child/student.

School Year

_____Parent Signature: _____ Date: _____

_____Parent Signature: _____ Date: _____

_____Parent Signature: _____ Date: _____

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Formulario de Consentimiento Médico

Estudiante: _____ Fecha de Nacimiento: _____ Grado: _____

Nombre del Padre: _____ Teléfono: _____

Dirección: _____ Ciudad_____ Zip _____

Proveedor de Seguro: _____ Número de Póliza: _____

Teléfono: _____ Número de grupo: _____

(_____) Se entiende que esta autorización está dada por adelantado de cualquier tratamiento, la atención o medicamento específico que puede ser dada por la enfermera de la escuela de HSAGP o asistente de salud de HSAGP a mi hijo/a. Entiendo, además, que el medicamento debe ser proporcionado por mí, el padre o tutor. (**Todos los medicamentos recetados deben tener una receta por un médico y los formularios firmados para administrar medicamentos de acuerdo a las órdenes prescritas**.)

(_____) Por este medio consentir y autorizar enfermera de la escuela HSAGP, HSAGP asistente de salud para administrar los siguientes medicamentos sin receta cuando sea necesario y para el bienestar de mi hijo/a. Además, entiendo que debo proporcionar el medicamento que se administra en su envase o recipiente de origen. (**Medicamentos OTC administrados más de 3 días consecutivos tendrán que tener una receta por un médico y receta**.)

(__) Ibuprofeno (__) El acetaminofeno (__) Ungüento Triple anti-biótico

(__) Benadryl (__) tópica de hidrocortisona (__) Caladryl (analgésico tópico / anti-picazón)

(__) Enjuague bucal / pasta de dientes (__) La benzocaína (alivio del dolor por vía oral) (__) Mentol (pastilla para la tos)

(__) Otro (s) _____

(_____) Entiendo que en caso de que mi estudiante está en un viaje de campo, el principal maestro / administrador / acompañante adulto tendrá la medicación en la ausencia de la enfermera. Así como yo los padres o tutores serán responsables de proporcionar al profesor / administrador o un acompañante adulto con un permiso firmado incluyendo mi información de seguro médico.

(_____) En el caso de que yo no soy capaz de llegar o ser localizado, y mi hijo está en la necesidad de asistencia médica de emergencia, doy mi consentimiento para la atención médica y la administración de medicamentos que se dará a mi hijo en mi ausencia por el bienestar de mi hijo el personal médico de

emergencia, la enfermera de la escuela de HSAGP o asistente de salud de HSAGP. Además entiendo que una copia de este documento será entregado al personal de emergencia. Solicito por los servicios médicos de emergencia para transportar a mi hijo a: **hospital de emergencia más cercano o**
El hospital de mi elección: _____.

(_____) Yo, el padre o tutor, autoriza antes de cualquier tratamiento, la atención o medicamento específico que debe darse por el hospital, la clínica o el médico en urgencias.

Lista de alergias a alimentos o medicamentos: _____
Mi hijo sufre de asma: No _____ Sí _____ Tipo de Medicamento: _____
Mi hijo sufre de ADHD: Si____ No ____ Tipo de Medicamento: _____
Mi hijo sufre de: _____ Tipo de Medicamento: _____
¿Será algún medicamento que guardar junto con la enfermera de la escuela para su hijo?
N / A ___ No ____ Si____
Por favor, añadir instrucciones especiales: _____
_____
_____

Yo, _____ padre o tutor legal de _____
con la fecha de nacimiento _____ doy consentimiento a la anterior:

Año Escolar
Firma _____Parent: _____ Fecha: _____
Firma _____Parent: _____ Fecha: _____
Firma _____Parent: _____ Fecha: _____
Firma _____Parent: _____ Fecha: _____

Yo rechazo todo lo anterior. Ningún tratamiento se debe dar a mi niño / estudiante.

Año Escolar
Firma _____Parent: _____ Fecha: _____
Firma _____Parent: _____ Fecha: _____
Firma _____Parent: _____ Fecha: _____

Harmony Public Schools

Administration of Medications at School

********** **Prescription and Non-Prescription Medication Requires Physician Signature** **********

Parents,

Your child may have an illness which requires medication for relief or cure that does not prevent his/her attending school. When possible, such medication should be scheduled to be taken at home. However, according to the Texas laws a medication may be dispensed to a student by school personnel. The following requirements must be met by the parent or legal guardian.

1. All prescription drugs dispensed through a physician's office must be in their original pharmacy container or packaging and labeled by the pharmacist or physician. The label must include:
   a. The student's name.
   b. The physician's name.
   c. The name and strength of the drug.
   d. Amount of drug to be given.
   e. Frequency of administration.
   f. Date prescription was filled.
2. All nonprescription drugs must be in their original container. The written request for administration of these over-the counter drugs, made by physician, must contain the following information:
   a. Full name of student.
   b. Name of drug.
   c. Amount of drug to be given.
   d. Scheduled hours when the drug is to be given.
   e. Reason drug is to be given.
   f. Date.
   g. Physician and Guardian's signature.
3. **All non-prescription drugs to be administered at school must be accompanied by a written request, signed and dated by a physician and legal guardian.** (See form below.)
4. **All prescription drugs to be administered from or kept in the school clinic must be accompanied by a written request signed and dated by the prescribing physician.**
5. Medications prescribed or requested to be given three (3) times a day or less are not to be given at school unless a specific time during school hours is prescribed by a physician or the school nurse determines that a special need exists for an individual student.
6. There will be no more than one medication per properly labeled container.
7. All medications will be stored and dispensed in the school clinic. Exceptions must be approved by appropriate school authorities in advance.
8. Students may not be in possession of prescription or non-prescription medications during school hours or at school-sponsored or school-related activities, on or off campus. Exceptions must be approved by appropriate school authorities in advance.
9. Natural and/or homeopathic-like products not FDA approved will not be dispensed by school district personnel.
10. In accordance with the Texas Nurse Practice Act, Rule 217.11, the school nurse has the responsibility and authority to clarify any medication order with appropriate licensed practitioner and/or refuse to administer medication that, in the nurse's judgment, is not in the best interest of the student.

Parental Permit to Administer Prescription or Non-Prescription Medication at School

Student Name (Last)	(First)	(MI)	DOB
Grade	Teacher		

Type of Medication ☐ Prescription ☐ Non-Prescription		Name of Medication	
Date to Begin Medication	Date to End Medication	Time to be Given	Amount to be Given
Reason medication being given			
Form of Medication ☐ Tablet ☐ Capsule ☐ Liquid ☐ Inhalant ☐ Other _____			Number or Amount Provided

Parents/Guardians – Please send only amount student needs to take at school in properly labeled, original container. No Controlled substances may be sent home with a student.		
My signature authorizes school personnel to give my child (named above) the medication (specified above) as directed.		
Parent/Guardian Name	Parent/Guardian Signature	Date
Home Phone	Mobile Phone	Work Phone

********* **Prescription and non-prescription medication require a Physician's Signature** *********	
Physician's Name	**Physician's Signature**
Physician's Office Phone	**Date**