TUCSON UNIFIED
SCHOOL DISTRICT

School Health Services
102 North Plumer Street
Tucson, Arizona 85719

HEALTH SERVICES REGISTRATION Pre-K - 12

School Year: 2020-2021

Student's Name: ______________________________ **Date of Birth:** __________ **Grade:**_____
Last First Middle

☐ My child wears glasses or contacts ☐ My child has seasonal allergies

☐ ⬅ Check here if your child **DOES NOT HAVE ANY HEALTH ISSUES** *(proceed to back of form)*

Emergency Care: In case of serious illness or injury and a parent/guardian cannot be reached, I consent for my child to be taken to a hospital, by ambulance if necessary, for medical care. TUSD will not be responsible for any costs of such not covered by insurance.

Parent/guardian is responsible for notifying the school of new or existing health concerns and for providing the school with any medication or equipment that the student will require during the school day. Contact the health office to obtain the correct procedural forms. ***Life-threatening conditions such as anaphylaxis, asthma, diabetes, or other conditions require individual health care plans/actions plans, medication permits, and staff training prior to your child attending.**

☐ **ALLERGIES** *(If checked, contact your school's health office staff)*

☐ Food: __________ ☐ Bee / ☐ Insect: __________ ☐ Medication: __________ ☐ Other: __________________

Describe the allergic reaction and the treatment: ____

☐ Injectable Epinephrine prescribed ☐ My child will carry Injectable Epinephrine *& has been instructed on Epinephrine use*

☐ Injectable Epinephrine will be kept in Health Office

☐ **ASTHMA** *(If checked, contact your school's health office staff)*

Triggers: ☐ Exercise ☐ Environmental ☐ Other: ________________

☐ Inhaler prescribed ☐ My child will carry inhaler *& has been instructed on inhaler use* ☐ Inhaler will be kept in health office

☐ My child was diagnosed with asthma but no longer uses an inhaler - date of last asthma episode: __________

☐ **DIABETES** *(If checked, contact your school's health office staff)*

☐ Type I ☐ Insulin Pump ☐ Pen ☐ Syringe ☐ Type II ☐ Healthcare provider plan

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☐ **EMOTIONAL/BEHAVIORAL/PSYCHOLOGICAL/DEVELOPMENTAL**

☐ ADD/ADHD ☐ Anxiety ☐ Depression ☐ Other Diagnosis(es): ____________________________

Receiving Treatment ☐Yes ☐ No

☐ **HEARING/VISION** (other than glasses or contacts)

☐ Hearing Impairment *Specify:*______________________ ☐ Visual Impairment *Specify*: ____________________

☐ **MOBILITY/ACTIVITY** *(If checked, contact your school's health office staff)*

☐ My child will need help with activities of daily living and/or health care procedures

☐ Activity restriction (*Specify):* ____________☐ My child uses an assistive device *(Specify):* ______________________

☐ **SEIZURES** *(If checked, contact your school's health office staff)*

Type of seizure: ________________ ☐ Date of last seizure: ____________

☐ Diastat or other emergency medication needed for seizures at school ☐ Daily seizure medication at home

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☐ **OTHER MEDICAL ISSUES** *(if you check any conditions below please explain in comments section and contact your school health office staff)*

☐ Cerebral Palsy ☐ Heart Condition ☐ Concussion (date: ______) ☐ Other: __________

Comments:

☐ **MEDICATION**

☐ Medications at school ____

If your child requires medication at school, contact the school health office staff. Requires medication permit.

Medication taken at home (Specify): ____

(over)

Grade:_____

SCHOOL PROVIDED OVER THE COUNTER MEDICATIONS

For students only in 6th – 12th grades:

For minor complaints I authorize the health office staff *(may be unlicensed individuals such as health assistants or office staff)* to give:

☐ Yes ☐ No - Acetaminophen <100lbs=325mg, ≥100lbs=650mg *(generic Tylenol for headache, menstrual cramps, or other minor discomfort)*

☐ Yes ☐ No - Ibuprofen <100lbs=200mg, ≥100lbs=400mg *(generic Advil for headache, menstrual cramps, or other minor discomfort)*

PERMISSION FOR FLUORIDE MOUTH RINSE PROGRAM TO REDUCE DENTAL CAVITIES

For students only in 1st – 5th grades

☐ **I WANT** my child to participate in the Arizona Department of Health Services fluoride mouth rinse program. I understand that I can withdraw permission at any time by notifying the school health office in writing.

☐ **I DO NOT WANT** my child to participate in the Arizona Department of Health Services fluoride mouth rinse program.

☐ I would like more information about dental services available at school. ☐ Please contact me

General Dentistry 4 Kids https://www.gd4k.com/

Insurance

☐ None ☐ Yes (Name of Insurance:____________________________________ ☐ AHCCCS ☐ TriCare)

Information provided on this form will replace and/or update any previous health information received with the exception of Life-Threatening Health Conditions *(contact nurse about removing this information).* It is the parent/guardian responsibility to notify the health office of any changes regarding their child's health status.

Parent/Guardian Name (printed):________________________ Parent/Guardian Signature:________________________ Date:_______