Young Peoples Workshops
YPW
SPANISH IMMERSION SCHOOL

Spanish@ypwKids.com
www.ypwKids.com

Student Name: _____ School Year: _____

Administration of Medication Policy

Medication is defined as any lotion, crème, drop, solution, over the counter or medication prescribed by a medical professional that is given to your child throughout the day.

Please check what applies:

☐ My child doesn't need medication during the school day

☐ My child needs medication during the school day
  ☐ I will submit the Administration of Medication form with my physician's signature

Please initial by each statement

____ I understand that I must supply the school with the medication and any equipment/supplies needed to administer the medication

____ I understand that all prescription medications must be labeled by a registered pharmacist

____ I understand the label must show the name of the medication, name of the student, name of the prescribing physician, date and directions by my child's physician

____ I understand that the physician will be called if a question arises about my child's medication

____ 911 will be called immediately in an emergency and I will be notified.

Authorization for Emergency Medical Release

In the event I cannot be reached to make arrangements for emergency medical care, I _____, authorize the person in charge to secure emergency medical care for my student, _____.

Please note every effort will be made to notify the parent or guardian in case of emergency
We need the following information in case of an emergency:
Name of Physician: _____ Phone Number: _____

Address: _____
If the parent/guardian is unavailable, please list other relative / persons to contact in case of emergency:
Name: _____ Phone Number: _____

Address: _____ Relationship: _____

By signing below I release YPW Spanish Immersion School and its employees from all liability for reactions which my child may suffer from the administration of the medication described. I also give consent to the emergency care facility to secure any and all necessary medical care for my child.

_____
Parent/Guardian Signature Date

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Immunization Records:

Please have your child's physician submit a record of immunization from your doctor's office.
For more information regarding State of Texas Immunization Requirements visit:
http://www.dshs.state.tx.us/immunize/

_____ I will submit an immunization record from my child's doctor by the first day of school

_____ I am excluding my child from the immunization requirements for reasons of conscience, including religious belief. I have attached an official notarized affidavit form developed and issued by the Department of Health Services. I understand this affidavit is valid for two years.

For information regarding Immunization Exemption visit the Department of State Health Services at:http://www.dshs.state.tx.us/immunize/school/default.shtm#exclusions

Varicella (Chickenpox) vaccine is not required if your child has had Chickenpox disease. If your child has had Chickenpox, please complete the following:
My child has had Varicella disease (Chickenpox) on or about (date):_____/_____/_____

_____
Parent/Guardian Signature Date

Wellness Statement

Please choose one of the following options

☐ Healthcare Professional's Statement: I have examined the above named child within the past year and find that he/she is physically able to take part in the school program.

_____
Healthcare Professional's Signature Date

☐ A signed and dated copy of a healthcare professional's statement is attached.

☐ Medical diagnosis and treatment conflict with the tenets and practices of a recognized religious organization, which I adhere to or am a member of. I have attached a signed and dated affidavit confirming this.

☐ My child has been examined within the past year by a healthcare professional and is able to participate in the school program. I will obtain a healthcare professional's signed statement and will submit it to the school by the first day of school.

Name and address of healthcare professional:

_____

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Vision and Hearing Screening:

this screening is required for all children 4 years of age and older. Once the screening is performed it is required every 4 years. Please have your child's physician fill out the form below and sign OR attach a separate, signed Vision and Hearing form.

☐ My child is under the age of four. I understand I will provide their vision and hearing screening when he/she turns four.

☐ My child is over four and I have attached the vision and hearing screening sheet

Food Liability Release:

_____I understand that YPW Spanish Immersion School will not be providing lunch or refrigeration and that it is my responsibility to prepare foods that meet daily nutritional standards.

Allergy List:

Does your child have any known allergies? YES NO

If yes, please specify below and provide a letter from your doctor explaining severity, type of reaction and medication

Allergy:_____
Type of Reaction: _____
Treatment: _____

Allergy:_____
Type of Reaction: _____
Treatment: _____

Allergy:_____
Type of Reaction: _____
Treatment: _____

Allergy:_____
Type of Reaction: _____
Treatment: _____

_____
Parent/Guardian Signature Date