Health Record Form

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 routine or "as needed" medications are not administered by the staff
____ I understand the school only administers medication during a life-threatening event
____ 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

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.

☐ 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, refrigeration or warming up the food 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