Verde Valley School

Dear Verde Valley School Parents/Guardians,

Greetings from the Health and Wellness Center at Verde Valley School (VVS). Our goal at VVS is to support student health by caring for the "whole child." In effort to reach this goal it is important that the following health packet is carefully reviewed and completed by August 1, 2016. When completing health forms please provide detailed, up-to-date, comprehensive health information.

A yearly physical exam with TB skin test is required for all students. In addition, students WILL NOT be permitted to come to campus until all Arizona State requirements have been met, as per Arizona State Law. Please see the Arizona School Immunization Requirements page in this packet for a complete list of required immunizations. It is important to take this form with you to your healthcare provider so they can review and complete any deficiency in immunizations.

Please use the checklist below to ensure all health forms are completed prior to your student's arrival on campus.

_____ Notice of Privacy Practices (page 2)

_____ Health Record and Physical Exam (page 3-5)

_____ Immunization Record Form (See enclosed Arizona School Immunization requirements) (page 6-7)

_____ Permission for Medical Care and Release of Confidential Information Authorization (page 8)

_____ Student Emergency Information (page 9)

_____ Proof of Insurance (page 10)

_____ Permission for Prescription Medications (page 11)

_____ Permission for Over-the-Counter Medications (page 12)

_____ Credit Card for Medical Services (page 13)

I am sincerely looking forward to being a part of your student's health and wellness here at Verde Valley School. If you have any questions or concerns please feel free to contact me by email at healthctr@vvsaz.org or call our main office at 928-284-2272.

Warm Regards,

Jennifer Welsh RN, BSN

Director of Health Services

Verde Valley School

Notice of Privacy Practices

This notice describes how medical information about your child may be used and disclosed, and how you get access to this information. Please review it carefully.

This Notice of Privacy Practices is mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). It describes how we may use and disclose your child's protected health information to carry out treatment, payment or health care operations, and for other purposes that are permitted by law. It also describes your rights to access and control your child's protected health information. "Protected health information" is information about your child, including demographic information, that may identify him or her and that relates to his or her past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. Any such new notice will be effective for all protected health information that we maintain at that time. Upon your request, you may obtain any revised Notice of Privacy Practices by calling us and requesting that a revised copy be sent to you in the mail, or asking for one at the time of your next visit.

USES AND DISCLOSURES OR PROTECTED HEALTH INFORMATIONS

Your child's protected health information may be used and disclosed, pursuant to 45 CFR 164.502, by the Health Center, his or her treating physician at the Health Center, our staff and others outside the Health Center that are involved in your child's care and treatment for the purpose of providing health care services to him or her. Your child's protected health information may also be used and disclosed to pay health care bills and to support the operation of the Health Center.

Set forth below are examples of the types of uses and disclosures of your child's protected health care information that the Health Center is permitted to make. These examples are not meant to be exhaustive, but rather to describe for you the types of uses and disclosures that may be made by the Health Center.

Treatment – We may use and disclose your child's protected health information to provide, coordinate or manage your child's health care and any related services. For example, we may disclose your child's protected health information to a physician or health care provider (e.g., a specialist or a laboratory) who, at the request of your child's physician or the Health Center, becomes involved in your child's care.

Payment - Your child's protected health information may be used, as needed, to obtain payment for your child's health care services. For example, obtaining approval for a hospital stay may require that your child's relevant protected health information be disclosed to a health plan to obtain approval for the hospital admission.

Healthcare Operations – We may use or disclose, as needed, your child's protected health information in order to support the normal business activities of the Health Center. Examples of these activities include, but are not limited to, quality assessment activities, employee review activities, training, licensing, and conducting or arranging for other business activities.

Verde Valley School

Health Record and Physical Exam Form

Please Attach Immunization Record

Name: _____Date of Birth: _____ Age: _____

Height: _____ Weight: _____

Temperature: _____ Pulse: _____ Respirations: _____ BP: _____

Allergies: _____

Reactions: _____

Past injuries, hospitalizations and/or surgeries (dates):

_____

_____

Verde Valley School believes supportive mental health care is essential to the well being of the student.

Has applicant ever been evaluated by a mental health care professional? Please give a brief description of condition: _____

_____

Name of mental health care provider: _____

Provider phone/address: _____

Has applicant ever been evaluated or treated for substance abuse issues? If yes, describe treatment:

_____

Is applicant under any medical treatment? □ Yes □No if yes, please explain: _____

_____

Provider phone/address: _____

Verde Valley School

Health Record and Physical Exam Form (continued)

Does applicant take any medication/supplements daily or as needed? □ Yes □ No

If yes, give medication dosage, frequency: _____

_____

Every student is required to participate in a sport. Please list any limitations:

_____

_____

Does applicant require any therapeutic measures or special care? Explain:

_____

_____

_____

Verde Valley School

Health Record and Physical Exam Form (continued)

Check if Normal	Comments
□ Vision	Uncorrected: L R Corrected: L R □ Glasses □ Contacts Should wear glasses during sports? □ Yes □ No
□ Hearing	Testing method:
□ ENT	
□ Heart	Rate: Rhythm: Murmur:
□ Lungs	
□ Abdomen	
□ Extremities	
□ Skin	
□ Back	Scoliosis?

Comments: _____

Based on history and physical exam, this student:

□ may participate in competitive athletics and physical activities.

□ should have the following health problems evaluated and treated prior to participation in competitive athletics or physical activities: _____

□ has health problems which prohibit participation in competitive athletics/physical activities and should be limited as follows: _____

Date of exam_____

Physician's Name_____

Signature _____

Address _____

_____

Phone _____

Fax _____

Physician's Stamp (if applicable)

Verde Valley School

Immunization Record Form

Student Name_____ Date of Birth _____

i.
ii. TUBERCULIN TEST REQUIRED FOR ADMISSION

Skin Test: Date Given: _____ Date Read: _____

Result: _____ (Positive results require a chest x-ray)

Chest x-ray: Date: _____ Result: _____

iii. IMMUNIZATIONS

Complete if this student is a new enrollee to Verde Valley School or if additional immunizations have been given this year. Statements such as **"UP TO DATE"** or **"COMPLETE"** will not be accepted. Admission to Verde Valley School may be denied on the basis of this information.

Vaccine	1st dose	2nd dose	3rd dose	4th dose	5th dose	6th dose
DTP/DT/Td/DTaP (Diphtheria, Tetanus & Pertussis)						
Tdap (required on or after 7th birthday)		X	X	X	X	X
IPV/OPV (Polio)						X
MMR (Measles, mumps, rubella)			X	X	X	X
Haemophilus Influenza Type B (HIB- required for pre-kindergarten)					X	X
Hepatitis B				X	X	X
Hepatitis A (optional)				X	X	X
Varicella (chickenpox)				X	X	X
Meningococcal (optional)			X	X	X	X
HPV (Human Papilloma Virus)				X	X	X
Other (including Influenza Vaccine)						

***Waiving of vaccines for any reason requires additional paperwork as mandated by the State of Arizona. I certify that the immunization dates are true to the best of my knowledge.**

_____ _____

Validating Signature (Doctor's Office) Date

Arizona Department of Health Services

Arizona School Immunization Requirements: Kindergarten - 12th Grade

- Students must have proof of all required immunizations, or a valid exemption, in order to attend school. Arizona law allows exemptions for medical reasons, lab evidence of immunity, and personal beliefs. Exemption forms are available from schools and at http://azdhs.gov/phs/immunization/school-childcare/requirements.htm. Homeless students are allowed a 5-day grace period to submit proof of immunization records.
- The immunization record for each vaccine dose must include the *complete* date and the doctor or clinic name.
- The statutes and rules governing school immunization requirements are:
  - Arizona Revised Statutes §15-871-874; and Arizona Administrative Code, R9-6-701–708

Please check requirements for each child's age and grade level in the chart below.

<table>
<tr><th>Age➔
Grade➔
Vaccine ↓</th><th>Under age 7</th><th>7 – 10 years</th><th>11 years and older</th></tr>
<tr><td></td><td>Kindergarten and above</td><td>Kindergarten-5th grade</td><td>6th through 12th grade</td></tr>
<tr><td>DTaP
(Proof of DTP or DT counts toward DTaP requirement)</td><td>4-5* doses
At least 1 dose at 4 years of age or older is required.

*A 6th dose is required if 5 doses have been given before 4 years of age.</td><td rowspan="3">3 DTaP and/or Td doses are required if all doses were given after 12 months of age.

Or

4 DTaP and/or Td doses are required if any of the doses were received before 12 months of age.

Tdap may be counted to meet the requirements above. Tdap is not required for 11 year olds until they enter 6th grade.</td><td rowspan="3">1 Tdap dose is required for students 11 years and older.

Students who completed the primary series of tetanus/diphtheria doses must receive a Tdap when 5 years have passed since the student's last tetanus/diphtheria dose.

Students who did not complete the primary series of tetanus/diphtheria doses before age 11 are required to receive a total of 3 doses, including 1 Tdap and 2 Td doses.

Tdap doses given prior to age 11 meet the requirement. A Td booster is required 10 years after the Tdap dose.</td></tr>
<tr><td>Td</td><td></td></tr>
<tr><td>Tdap</td><td></td></tr>
<tr><td>Meningococcal</td><td></td><td>Not required but may be counted as valid when given at this age.</td><td>1 dose is required.</td></tr>
<tr><td>Polio</td><td colspan="3">3-4 doses
4 doses meet the requirement. 3 doses meet requirements if dose #3 was given at 4+ years of age.
(Not required for students 18+ years of age.)</td></tr>
<tr><td>MMR</td><td colspan="3">2 doses
A 3rd dose will be required if dose #1 was given before more than 4 days before the 1st birthday.</td></tr>
<tr><td>Hepatitis B</td><td colspan="3">3 doses
A 4th dose will be required if the third dose was given before 24 weeks of age.</td></tr>
<tr><td>Varicella</td><td colspan="3">1 dose is required if the 1st dose was given before 13 years of age.
2 doses are required if the 1st dose was given at 13 years of age or later.

Students attending school or preschool in Arizona prior to 9/1/2011 with parental recall of chicken pox disease are allowed to continue attendance with parental recall of disease. Students enrolling for the first time after 09/01/2011 are required to present proof of varicella immunization or a valid exemption for medical reasons, laboratory evidence of immunity or personal beliefs.</td></tr>
</table>

Note: ADHS observes a 4-day grace period for vaccine ages and intervals, except for the space between two live vaccines such as Varicella and MMR, which must be given at least 28 days apart if they are not administered on the same day.

Childcare and preschool immunization requirements are posted at http://azdhs.gov/phs/immunization/school-childcare/requirements.htm.

Verde Valley School

Permission for Medical Care and Release of Confidential Information Authorization

I (we), parent(s)/legal guardian of _____, hereby give consent to
(Print student's full name)
Verde Valley School or other instructional support staff associated with, but not limited to, The Verde Valley School Staff to carry out accepted procedures for diagnosis, immunization, medical and surgical treatment, or counseling for my son/daughter/ward. In rare instances, a medical, surgical or psychiatric emergency arises in which a written consent by the parent or guardian is legally required, but the proper person cannot be located. In such circumstances, in order to avoid delay which might jeopardize the life or recovery of a student, we also request the following permission from the parents or guardians, with the understanding that effort will be made to contact them in an emergency.

I hereby grant permission to The Verde Valley School and/or other health care providers including, but not limited to, Urgent Care (Sedona) and Verde Valley Medical Center, or, if on a school trip, the nearest hospital emergency room to give medical care, emergency care, necessary anesthesia and/or perform necessary surgery on my son/daughter/ward.

I hereby grant permission to The Verde Valley School and/or necessary medical personnel to have access to my son/daughter/ward's medical records in the event of admission to a medical facility. I hereby authorize The Verde Valley School to release medical information (including information related to drug or alcohol treatment) as required to carry out treatment, health care operations and payment, unless more specific authorization is required by law. I also authorize other health care providers who have provided medical treatment or related services to my son/daughter/ward including, but not limited to The Verde Valley School, to release medical information (including information related to drug or alcohol treatment) to the medical facility deemed necessary to carry out treatment and health care operations, unless more specific authorization is required by law.
I authorize the release of medical information to my insurance company as may be necessary to determine benefits entitlement and to process payment claims for health care services rendered.
When parents are separated or divorced, and absent a court order to the contrary, The Verde Valley School presumes that a non-custodial parent has access to health information and input to the same extent as a custodial parent.

My signature below indicates my consent to the above matters. This consent will remain in effect throughout my child's enrollment and attendance at The Verde Valley School unless it is revoked by me or my son/daughter/ward's other parent or guardian.

_____/_____/_____
Parent/Guardian (Print) Parent Signature Date

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Home Address: _____

_____

Students Date of Birth: _____

Verde Valley School

Student Emergency Information

Name of Student: _____

Preferred Name: _____Date of Birth: _____ Grade: _____

Social Security Number: _____Student Cell Number: _____

Please check appropriate boxes:

□ Female □ Male □ New Student □ Returning Student □ Boarding □ Day □ International

Parent/Guardian 1

First Name: _____ Last Name: _____

Relationship to Student: _____

Home Phone: _____ Cell Phone: _____

Home Address: _____

Date of Birth: _____

Parent/Guardian 2

First Name: _____ Last Name: _____

Relationship to Student: _____

Home Phone: _____ Cell Phone: _____

Home Address: _____

Date of Birth: _____

Emergency Contact

First Name: _____ Last Name: _____

Relationship to Student: _____

Home Phone: _____ Cell Phone: _____

Home Address: _____

Verde Valley School

PROOF OF INSURANCE

Step 1:
Place front of your insurance card facing up
in this space and then photocopy

Step 2:
Place back of your insurance card facing up
in this space then photocopy

Step 3: Scan, fax, or mail to Verde Valley School. Make sure information is legible before submitting.

Verde Valley School

Permission for Prescription Medications

*Parent or guardian and **Physician signature** **required***

_____ _____
Student Name Date of Birth

_____ _____
Parent Name Date of Birth

Current medications child takes including drug name, dosage, route, time(s) of day and if taken with food.
Are these medication(s) to be administered at school? _____ Yes _____ No

Medication 1: _____ Taken with food? Yes No

Dosage: _____ Route: _____ Time of Administration: _____

Self-carry? Yes No

Medication 2: _____ Taken with food? Yes No

Dosage: _____ Route: _____ Time of Administration: _____

Self-carry? Yes No

Medication 3: _____ Taken with food? Yes No

Dosage: _____ Route: _____ Time of Administration: _____
Self-carry? Yes No

If yes, I give permission to the school nurse or other authorized personnel to administer the above medication(s) to my child. Should a change in any of the above information occur, I understand that a revised, written physician's statement and parent authorization must be submitted.

_____ _____
Parent/Guardian Signature Date

_____ _____
Physician or Nurse Practitioner Name Date

_____ _____
Physician or Nurse Practitioner Signature Date

Signature is required for all medications unless prescribed for a short term.
(i.e. Amoxicillin for 10 days; pharmacy-labeled bottle will suffice.)

Verde Valley School

PERMISSION FOR OVER-THE-COUNTER MEDICATIONS

Please choose **ONE** option only:

☐ I withhold permission and **DO NOT** allow Verde Valley School or its Health Center to administer any over-the-counter medications. By checking this box, I further acknowledge that VVS Health Center may, at its discretion, arrange for my child to see a medical provider should the need arise.

☐ My child **HAS PERMISSION** to receive over-the-counter medications at the discretion of the School Nurse per manufacturer's directions. My child is **NOT PERMITTED** to keep any over-the-counter medications on their person or in their dorm room.

☐ My child **HAS PERMISSION** to receive over-the-counter medications at their own discretion. My student **IS PERMITTED** to keep medications and administer them to him or herself as needed. My student understands the administration and effects of the medication and is reliable about taking the medication him or herself. The medication will **NEVER** be shared with another person. Such behavior is a violation of a major School rule and could be grounds for dismissal. We understand that this privilege may be revoked if warranted.

MEDICATION AGREEMENT

Verde Valley School cannot and does not assume any responsibility for determining the appropriateness of medications and dosages. Modifications or changes to prescription medication must be made in writing by the prescribing physician and sent to the Health and Wellness Center. The student is responsible for obtaining the medication from the Health Center or School designee prior to vacations or other times when the student will be away from campus. It is the responsibility of the student to take all medications as prescribed and in timely manner. A student who misses or is late for medication at the Health and Wellness Center may be given a disciplinary violation. Non-compliance with prescribed or over-the-counter medication will be communicated to the parents.

My signature below attests that I have read this entire agreement and that I understand it and its terms.

_____ _____

Parent/Guardian Signature and Date

Student Signature and Date

Verde Valley School

Credit Card for Medical Services

The information being requested is to enable payment of services rendered in the local community for your child while a student at Verde Valley School. Please fill out this form and return it as soon as possible.

Verde Valley School provides a small health and wellness center for treatment of minor injuries and illnesses. If your child requires care by a doctor, he/she will be sent to the local physician or treatment center. Any co-pays or fees that are due at the time of treatment will be paid using a credit card or cash. You may call Verde Valley School Health and Wellness Center at 928-284-2272 if you have any questions about local doctors, urgent care centers or hospitals.

Please provide the Health and Wellness Center with credit card information to pay for prescribed medications and medical expenses not covered by your insurance. This information will be kept in a secure place and used only for payment of pharmacy or physician charges.

Today's Date: _____

Student's Name: _____

_____ Visa

_____ MasterCard

_____ Discover

Full Name on Credit Card: _____

Card Number: _____

Expiration Date: _____ Security Code (located on back left of card): _____