Greetings from the Health Center at Verde Valley School!

Our goal is to support student health using a holistic approach to wellness. This means not just focusing on your child's physical health but all aspects of their health that could affect their campus life including mental, behavioral, and relational health. To reach this goal we need your full support in completing this packet and providing important details about your child.

This health packet needs to be fully completed and returned *AS SOON AS POSSIBLE.*

When your child arrives to VVS it is important they are ready to be a healthy community member. Please use the checklist below to ensure all required documentation is submitted:

_____ PAGE 3 - Permission for Medical Care and Release of Confidential Information
_____ PAGE 4 - Student Emergency Information
_____ PAGES 5 & 6 - Health Record and Physical Exam – *filled out and signed by medical professional*
_____ PAGE 7 - Immunization Record Form - *filled out and signed by medical professional*
_____ PAGE 8 - Medication Agreement
_____ PAGE 9 - Medication / Supplements List – *if taking medication/supplements*
_____ PAGE 10 - Credit Card for Medical Services
_____ PAGE 11 - Flu Shot Consent Form – *optional*
_____ Copy of current immunizations – *provided by medical professional*
_____ TB skin test documentation – *provided by medical professional*
_____ Copy of health, dental, and vision insurance cards (front and back)

If your child arrives to campus without a current TB skin test or up-to-date immunizations we must contract the Yavapai County Health Department to fulfill this Arizona State Requirement. This will result in a fee of $80 to the student account plus any fees charged by Yavapai County Health Department for their services. If you would like to opt out of required vaccinations you **must** contact the Yavapai County Health Department, as their policies and exemption forms are updated annually. Yavapai County Health Department contact information:

- Email: web.health@yavapai.us
- Phone: 928-639-8132

We are looking forward to being a part of your student's daily health and wellness while here at Verde Valley School. If you have any questions or concerns please contact me directly.

Your Nurse,

Mattie Guelinas, RN
Director of Health Services

healthcenter@vvsaz.org
928-284-2272 ext. 24

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.

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Permission for Medical Care and Release of Confidential Information

I, parent/legal guardian of _____(Print student's full name), hereby give consent to Verde Valley School or other instructional support staff associated with, but not limited to, Verde Valley School Staff to carry out accepted procedures for diagnosis, immunization, medical and dental treatment, or counseling services for my child/ward. An emergency may arise that requires written consent by the parent or guardian. In such circumstances and 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. Effort will be made to contact each in an emergency as soon as practical.

I hereby grant permission to Verde Valley School and/or other health care providers to give medical care, emergency care, and necessary anesthesia and/or perform necessary surgery on my child/ward.

I hereby grant permission to Verde Valley School and/or necessary medical personnel to have access to my child/ward's medical records. I hereby authorize 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 and other health care providers.

I authorize the release of medical information to my insurance company as may be necessary to determine coverage and to process payment claims for health care services rendered. When parents are separated or divorced, and absent a court order to the contrary, 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 for the school year at Verde Valley School unless it is revoked by me or my child/ward's other parent or guardian.

_____/_____/_____

Print Parent/Guardian Name (Last/Family Name, First) Parent/Guardian Signature Date

Parent/Guardian Date of Birth:_____ Student Date of Birth: _____

MM/DD/YYYY MM/DD/YYYY

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Student Emergency Information

Student Name: _____ Grade: _____

Preferred Name:_____ Student Cell Phone #: _____

Home Country:_____

Select all that apply: ❑ New Student ❑ Returning Student ❑ Boarding (❑ 5 or ❑ 7 days) ❑ Day Student

Parent/Guardian/Primary Contact

Mr./Mrs./Ms./Miss First Name: _____ Last/Family Name:_____

Relationship to Student: _____ Cell Phone: _____

Home Phone: _____ Work Phone: _____

Home Address: _____

Email address:_____ Preferred method of contact: _____

Primary Language: _____ English Translation Preferred? _____

Parent/Guardian 2

Mr./Mrs./Ms./Miss First Name: _____ Last/Family Name:_____

Relationship to Student: _____ Cell Phone: _____

Home Phone: _____ Work Phone: _____

Home Address: _____

Email address:_____ Preferred method of contact: _____

Primary Language: _____ English Translation Preferred? _____

Emergency Contact

Mr./Mrs./Ms./Miss First Name: _____ Last/Family Name:_____

Relationship to Student: _____ Cell Phone: _____

Home Phone: _____ Work Phone: _____

Home Address: _____

Email address:_____ Preferred method of contact: _____

Primary Language: _____ English Translation Preferred? _____

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Verde Valley School

Student Health Record and Physical Exam Form

(to be filled out by a medical professional)

First Name: _____ **Last/Family** Name: _____

Nickname: _____ Date of Birth (MM/DD/YYYY): _____

Age: _____ Height: _____ Weight: _____

Pulse: _____ Respirations: _____ BP: _____ O2 sat:_____ Temp: _____

Allergies / Sensitivities to medications, food, or environment & reactions:

❑ None_____

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

❑ None_____

Dietary Restrictions:

❑ None_____

Athletic/Sport Limitations:

❑ None_____

Does the student have any ongoing medical treatment? ❑ Yes ❑ No

Has the student ever been evaluated/treated for substance abuse issues? ❑ Yes ❑ No

Has the student ever been evaluated/expressed concern for mental health needs?

Examples: anxiety, depression, difficulty concentrating, etc. ❑ Yes ❑ No

If yes to any of the above questions, please explain:

_____

_____

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	Medical History
Vision	❑ Glasses ❑ Contacts *Attach copy of prescription ❑ No current concerns
Hearing	Testing method: ❑ No current concerns
Heart/Circulation	❑ No current concerns
Ears, Nose, Throat	❑ No current concerns
Lungs/Respiratory	❑ No current concerns
Abdomen/Gastrointestinal	❑ No current concerns
Extremities	❑ No current concerns
Skin	❑ No current concerns
Back/Spine	❑ No current concerns
Kidneys/Genitourinary	❑ No current concerns
Immune Function	❑ No current concerns
Mental Health Concerns	❑ None ❑ Depression ❑ Anxiety ❑ Other:_____

Comments/Concerns:_____

_____

_____

Date of exam _____

Provider's Name _____

Provider's signature _____

Address _____

_____

Phone _____

Provider's Stamp

(if available)

3511 Verde Valley School Rd. Sedona, AZ 86351 Phone: 928.284.2272 Online: www.vvsaz.org

Immunization Record Form

Student Name: _____ Date of Birth (MM/DD/YYYY): _____

TUBERCULIN (TB) SKIN TEST REQUIRED **ANNUALLY**
attach official documentation to this health packet

IMMUNIZATIONS

- Complete this page only if the student is new to Verde Valley School.
- Attach all immunization documentation to this health packet.
- The following page outlines the Arizona minimum required immunizations.
- Consult with your health care provider for additional recommended vaccinations.
- Document the date given in a **MM/DD/YY** format.

Vaccine	1st dose	2nd dose	3rd dose	4th dose	5th dose	6th dose
DTaP/DTP Diphtheria, Tetanus & Pertussis						
Td Tetanus & Diphtheria						
Tdap Tetanus, Diphtheria, acellular Pertussis						
IPV/OPV Polio						
MMR Measles, mumps, rubella						
Hep B Hepatitis B						
Varicella Chicken Pox						
Meningococcal						
Hep A Hepatitis A						
HPV Human Papilloma Virus						

Please attach positive titer lab work if applicable. Waiving of vaccines for any reason requires additional paperwork as mandated by the State of Arizona (see page 1).

I certify that the immunization dates are true to the best of my knowledge.

Validating Signature (Medical Provider) Date

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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://www.azdhs.gov/phs/immun/back2school.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/1st/2nd</td><td>2nd through 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 chickenpox 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. Parental recall of disease will not be accepted.</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.

Arizona Immunization Program Office • 150 North 18th Avenue, Suite 120
Phoenix, AZ 85007 • (602) 364-3630

Revised July 2017

MEDICATION AGREEMENT

Please choose ONE:

❑ My child **HAS PERMISSION** to receive over-the-counter medications at the discretion of Verde Valley School per manufacturer's instructions.

❑ I withhold permission and **DO NOT ALLOW** Verde Valley School to administer any over-the-counter medications.

MEDICATION POLICIES

- No student is permitted to keep any medications or supplements on their person or in their dorm room. The only exception to this policy is birth control.
- Students with any medications or supplements must turn them in to the School Nurse or Administrative Staff immediately upon arrival to campus. The medications will be counted and the amount will be verified with parents/guardians. Failure to turn in medications or supplements upon arrival will result in disciplinary action.
    - Student medication/supplements brought to campus for occasional use will be held for safe keeping in the Health Center
- Students are responsible for communicating with the Health Center their medication needs when leaving campus. Parents/Guardians will be notified of the number of pills provided for off-campus use. For school breaks and holidays parents/guardians are expected to count and report the number of pills expected to return to campus.
- Modifications or changes to medications or supplements must be communicated via email to healthcenter@vvsaz.org.
- A student's non-compliance with this policy will be immediately communicated to the parents/guardians and result in disciplinary action.

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

_____ _____

Parent/Guardian Signature Date Student Signature Date

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Medications and Supplements

Please list all medications or supplements taken by your child (regardless if taken at school or home).

If you are unsure of the number of pills that will be sent to campus leave it blank and email the exact amount to healthcenter@vvsaz.org at a later date.

Make copies of this page if you are sending more than 3 medications/supplements.

If your child is a boarder and on prescription medication please transfer the prescription to: Weber's Pharmacy @ 928-284-2202.

_____

Student Name Date of Birth (MM/DD/YYYY)

1. Medication/Supplement: _____ Dosage: _____

Reason taken: _____

Number of pills sent to campus:_____ Special Instructions: _____

2. Medication/Supplement: _____ Dosage: _____

Reason taken: _____

Number of pills sent to campus:_____ Special Instructions: _____

3. Medication/Supplement: _____ Dosage: _____

Reason taken: _____

Number of pills sent to campus:_____ Special Instructions: _____

I give permission to the school nurse or other authorized personnel to administer the above medications/supplements to my child. I understand that a change in any of the above information must be communicated via email to healthcenter@vvsaz.org at your earliest convenience.

_____

Parent/Guardian Signature Date

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Verde Valley School

Credit Card for Medical Services

THIS FORM IS KEPT AT HIGHEST SECURITY

Verde Valley School Health and Wellness Center is for treatment of minor injuries and illnesses. If your child requires care by a provider, he/she will visit the local treatment center (mostly likely the Emergency Room). Any co-pays or fees that are due at the time of treatment will be paid using a credit card. This credit card will also be used to cover any medications or supplies needed from a pharmacy.

In the rare occurrence the credit card is declined, the charge will be billed to the student account with a $20 processing fee for each instance. Parents agree to deposit and maintain sufficient funds upon notification of charges. Health Savings Accounts may not be accepted by all pharmacies and providers.

Student's Name: _____

_____ U.S. Based Credit Card
_____ International Credit Card
_____ Health Savings Account

Full Name on Credit Card: _____

Card Number: _____

Expiration Date: _____ Security Code (located signature panel): _____

Card holder's signature: _____

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COMPLETE AND SIGN THIS FORM FOR YOUR CHILD TO RECEIVE A FLU SHOT ON OCTOBER 24, 2018. ***Verde Valley School***

SEASONAL INFLUENZA CONSENT FORM (18 years &under) 2018-19
YAVAPAI COUNTY EDUCATION SERVICE AGENCY 2970 Centerpointe East Drive PRESCOTT, AZ. 86301 PH:928-771-3544

CONSENT FOR THE SCHOOL NURSE TO ADMINISTER INFLUENZA VACCINE

INFORMATION ABOUT THE PERSON RECEIVING THE IMMUNIZATION – PLEASE PRINT CLEARLY

Last Name	**First Name** **Middle Initial**		**CELL PHONE NUMBER**
Mailing Address			**HOME PHONE NUMBER**
City **State**		**ZIP CODE**	**WORK PHONE NUMBER**
Birth Date	**Age**	**Circle one:** **MALE FEMALE**	**SCHOOL NAME** **GRADE**

*****Please answer the questions below for the person receiving the vaccine today:*** *circle yes or no*

1. Has your child ever been immunized against the flu?	Yes	No
2. Has your child had a flu vaccination in the last 6 months?	Yes	No
3. Does your child have an allergy to eggs that causes a dangerous reaction?	Yes	No
4. Does your child have asthma? How often does he/she us an inhaler?	Yes	No
5. Has your child had a **serious** reaction to a previous flu shot?	Yes	No
6. Has your child ever had Guillian-Barre Syndrome? This is a paralytic illness.	Yes	No
7. Is your child pregnant or is there a possibility that she is pregnant?	Yes	No

IF YOU ANSWERED "YES" TO QUESTIONS 3-7 YOU MUST CONSULT WITH A NURSE BEFORE THE VACCINE CAN BE GIVEN.

Your child qualifies for immunizations through the vaccine for children program because he / she:

PLEASE CHECK ONE

1	Is privately insured
2	Is in enrolled in AHCCCS
3	Does not have health insurance
4	Is American Indian or Alaskan Native
5	Insurance does not pay for immunizations

NASAL MIST IS NOT AVAILABLE FOR THE 2018-19 FLU SEASON

_____ **FLU INJECTION (shot)** I have read the Vaccine information sheet or have had explained to me the information about inactivated influenza vaccine (VIS 8-7-15).____ .

I have been given a copy and have read, or have had explained to me, the information in the "Vaccine Information Statement(s)" for the Influenza Vaccine checked above. I believe I understand the benefits and risks of the vaccine requested and ask that the vaccine(s) checked be given to the person named above for whom I am authorized to make this request. **My signature gives permission for the nurse to administer the complete series of immunizations**. If your child is under 9 years old and never been immunized with the influenza vaccine they will need a second dose approximately one month after the first. I may revoke my consent for immunizations anytime in writing.

I agree for the health care provider giving vaccinations to release information about all vaccinations given to the Arizona State Immunization Information Systems (ASIIS), other health care providers and schools in order to avoid receiving unnecessary vaccinations and to provide information about what immunizations have been received. I understand that I am not required to agree to release this information in order to receive the vaccinations I request.

PLEASE SIGN AND THEN CLEARLY PRINT YOUR NAME AFTER YOUR SIGNATURE.

☒ ☒

Signature of Parent or Guardian **Print Name** **Date**

DATE ADM:		**DATE ADM:**
LOT # **1ST DOSE**		**LOT #** **2ND DOSE**
EXP:	**IM SITE: DEL ☐ LEFT ☐ RIGHT ☐ VAST.LAT ☐**	**EXP:**

Signature of Administrator **DATE** **Signature of Administrator** **DATE**

NEEDS SECOND DOSE ☐ YES ☐ NO ☐ HISTORY INCOMPLETE

PARENT NOTIFIED OF ADM. OF SECOND DOSE DATE AND TIME_____