Mora Independent School District

Nurse's Office
Shannon Trujillo, RN School Nurse
Berna Trujillo, Secretary/Health Aide
P.O. Box 179
Mora, New Mexico 87732
Phone: 575-387-3113 or 575-387-3224
Fax: 575-387-3160

Dear Parents:

I would like to take this time to welcome your child to the Mora Independent School District for the 2016-2017 school year.

In order to ensure a healthy environment for your child you are required to complete all sections of the attached "Emergency Notification/Health History" and Over the Counter Medication Consent" forms. The forms are lengthy, however, they are important in the event that your child becomes ill or is involved in an accident during school hours or on school sponsored activities. Further, the forms assist us in identifying any routine health care your child may need.

If your child is on medication that requires administration in the school, either on a regular basis or for emergency, you must request and complete a medication authorization form. The form needs to be signed by your child's health care provider and submitted to the nurse's office. Additionally, your child's primary care provider will need to complete the form. Also, you will be required to provide the medication in an original labeled bottle with appropriate dispensing information to the nurse's office.

The nurse's office will continue to be located on the south side of administration building to offer routine school nursing services. Additionally, you will still have access to School-Based Health Center services on an appointment or walk-in basis.

Sincerely,

Shannon Trujillo, R.N. School Nurse
Berna Trujillo, Secretary/ Health Aide

MORA INDEPENDENT SCHOOL DISTRICT
EMERGENCY NOTIFICATION/HEALTH HISTORY FORM

Student's Name:_____ Birth Date:_____
Parents/Guardian:_____Home Phone:_____
Address:_____ Work Phone:_____
Emergency contact person: _____ Emergency Phone:_____
Health Insurance: _____ Grade/Teacher _____
Student's Medical Provider:_____ Phone Number:_____
Student's Dentist:_____ Phone Number:_____

If the above named student becomes seriously ill or injured at school and the family or emergency contact person cannot be reached immediately, I hereby authorize school personnel to call and/or arrange for the transportation of the student to:

Medical Provider: _____Phone Number:_____
Dentist: _____ Phone Number: _____
Hospital: _____ Phone Number: _____

If this physician or dentist is not available, it is understood that the school will call a doctor and/or will send the students if necessary, to the nearest emergency facility or care and authorize these providers and/or hospital to give any reasonable and customary health care deemed necessary. It is understood, that I will pay for any emergency care and transportation costs incurred, unless costs are otherwise covered by my health insurance. No liability shall be imposed on any school official or the school district who, in good faith, have attempted to comply with this section.

Signature of Parent/Guardian:_____ Date: _____

HEALTH HISTORY INFORMATION

Please indicate if the student has had or is currently under treatment for any of the following conditions. Enter the year or child's age when the problem first occurred.

_____ALLERGIES (seasonal, hay fever)
_____ASTHMA (inhaler Y___N_____
_____BLEEDING DISORDERS
_____DIABETES
_____ EAR/HEARING PROBLEMS
_____ EYES/VISION
_____HEADACHES
_____HEART PROBLEMS
_____HEPATITIS (TYPE)
_____RESPIRATORY PROBLEMS
_____URINARY PROBLEMS (bladder/kidneys)
_____NEUROLOGICAL DISORDERS (seizures)
_____SURGERIES
_____ OTHERS (explain):_____

Comments for problems listed above:

Is the student ALLERGIC TO ANY MEDICATION? (Name/reaction)_____

_____ Does your child have an epi-pen?_____

Current Medications (Name, dose, how often it is taken)_____

Note: Any medications that require administration in the school, including over the counter medications require a consent form. With the exception of inhalers and diabetes medication, students are not allowed to carry other medications with them at school. Arrangements must be made to store them in the Nurse's Office. Please request a medication authorization form at the Nurse's Office. Please keep the school nurse informed of any changes in your child's health during the school year. Health information will be shared with school staff on a "need to know" basis only in accordance with district policy and FERPA/HIPPA privacy regulation.

MORA INDEPENDENT SCHOOL DISTRICT

CONSENT FOR "OVER THE COUNTER" MEDICATION ADMINISTRATION

Student's Name_____ Birth date _____

If my child becomes ill at school and other non-medication treatments have been attempted such as snack, water, rest, etc., I give permission to administer:

_____Tylenol _____ Ibuprofen_____ Calamine Lotion, _____Antibiotic Ointment

_____Eye Drops _____Benadryl _____ Burn Spray. Other (medications provided by parents must be un-opened, clearly labeled bottles).

Yes_____No_____Date:_____
Parents or Guardian Parent or Guardian

Comments:_____

_____

_____

_____

Note: The school nurse will utilize local board of education policy and state guidelines for safe storage and administration of medication in the school.