Tséchízhí Diné Bi'ólta'
ROUGH ROCK COMMUNITY SCHOOL, INC.

SCHOOL BOARD
Rena Mann - President
Crystalyne Curley - Vice Presider
Perry Begay - Member

SCHOOL HEALTH REGISTRATION PACKET SY: 2022-2023

Dear Parent/Guardian,

Welcome to Rough Rock Community Schools. This is the health portion of the registration packet for your child. This information is what the nurse and health technician rely on if your child needs any medical attention. Please provide any health issues, medications being taken, special health needs and allergies (food, animal, plant or chemicals) that your child is sensitive to.

The following programs are coordinated through the school nurse that serve the students:

1. **SMILE Dental** ..... for qualified K-12 students.
2. **IHS Dental – Many Farms** .....specific elementary students
3. **Vision/Hearing Screening** .....Pre-school, K-2, 6th, 9th and all SPED students & any student who has had previous problems. No permission is required and mandatory in AZ state.
4. **Flu Clinic** ..... All students with proper permission slip
5. **Teen Clinic** ..... Grade 9-12 students with signed application
   Sports Physicals ..... Parents/guardians must fill out their portions of the form & sign before Teen Clinic can do the physical.
6. **School Health Permit**.....information regarding student that will be kept at the Nurse's office and needed permissions from parents for student to have medication treatment/dispensed at school.

Please keep your child home for:

1. Generalized Rash
2. Reddened, draining eyes
3. Untreated live Head Lice.
4. Vomiting or Diarrhea for 24 hours after cessation
5. Oozing wounds that cannot be kept dry & covered
6. Fever of 99.0 or more, for the duration of the fever and an additional 24 hours without fever-reducing medication. ***OR ANY COVID LIKE SYMPTOMS!!***

IMPORTANT: Immunizations must be updated as of JUNE 2022
(AZ State Regulation Requirement)

All permission slips are included in the health registration packet, without the signed permission, your child will not be able to take advantage of these above services. If your phone numbers change, please have your child inform the nurse and front office. This is very important to keep communication open with student's families. Thank you for your help.

Ms. Trudi Burbank/ School Health Technician
Phone: (928) 728-3790/3709

Tsé ch'ízhí Diné Bí'ólta'
ROUGH ROCK COMMUNITY SCHOOL, INC.

SCHOOL HEALTH REGISTRATION PACKET SY: 2022-2023

Dear Parent/Guardian,

There has been some confusion in our procedure at the ELEMENTARY SCHOOL for handling students with head lice. This letter is clarifying what to expect if the situation arises.

1. In the event that there is an outbreak of head lice, the school will start out the year with a supply of shampoo and combs to treat the condition in students.
2. The student will be brought to the nurse office and examination will be performed. The technique used is to spray a hair detangler on the hair and use a very fine comb to systematically comb through the entire head of hair. Once it has been confirmed that the student has nits or adult lice present, a treatment will be done at school.
3. A note will be sent home with your child explaining that the treatment was performed. A second treatment will be provided to the student seven (7) days later.

As the year progresses, there may come a time when those supplies have been depleted. If the budget does not allow replenishing the shampoo and comb supplies, you will be called to take your child home. Your child will need to be treated at the clinic of your choice. A note will need to be provided upon your child's return to school.

I AGREE TO THE PROCEDURE LISTED ABOVE: _____
(Parent/Guardian Signature)

I WILL HANDLE THE SITUATION MYSELF: _____
(Parent/Guardian Signature)

Note: If you choose to handle the situation yourself, you will be called to come and get your child from school. Readmission will require a parent note and sale slip for the shampoo.

Ms. Trudi Burbank/ School Health Technician
Phone: (928) 728-3790/3709

Rough Rock Community School
2022-2023 Health Permit

Student Name: _____ DOB: _____ Grade: _____ Gender: _____

Mailing Address: _____ City: _____ State: _____ Zip Code: _____

CHC#: _____ Census# _____ Social Security#: _____

Father's/GuardiansName: _____ HomePhone#: _____

Home Location: _____

Employer: _____ Work Phone#: _____

Mother's/GuardiansName: _____ HomePhone#: _____

Home Location: _____

Employer: _____ Work Phone#: _____

Who is child living with? _____ Relationship: _____

Who is the legal Guardian? _____

Other children at RRCS? _____

**** ARIZONA SCHOOL IMMUNIZATION LAW REQUIRES PROOF OF IMMUNIZATION AT ENROLLMENT ****

Emergency Contacts (other than parents/guardians)

Name: _____ Home Phone#: _____

Home Location: _____

Work Phone#: _____

Name: _____ Home Phone#: _____

Home Location: _____

Work Phone#: _____

In case of EMERGENCIES which require medical attention during school hours, I give permission for my child to be transported to Chinle/Kayenta IHS for the rendering of such Medical Services as deemed necessary in the option of the attending physician or primary care provider.

Parent/Guardian Signature: _____ Date: _____

PLEASE DO NOT SEND SICK STUDENTS TO SCHOOL!!

Rough Rock Community School

Health Questionnaire and Consent Form

Health History

Has your child had?

Asthma	Yes	No	When?	Vision/Hearing Problem	Yes	No	When?
Uses Inhaler	Yes	No		Hepatitis	Yes	No	
Chicken Pox	Yes	No		Allergies	Yes	No	
Diabetes	Yes	No		Dietary Restrictions	Yes	No	
Eye (Glasses/Contacts)	Yes	No		Lactose Intolerant	Yes	No	
ADD/ADHD	Yes	No		Past Surgeries	Yes	No	
COVID-19	Yes	No		Heart Condition	Yes	No	

Please explain any "Yes" answers: _____

My child is usually seen at _____ hospital.

My child has special medical needs (Active Problems). (Please list): _____

If your child uses an inhaler, Please get an extra inhaler to leave at the school and fill out a medication dispense form with the Nurse.

MEDICATIONS: Is your child taking any medications? **Yes** _____ **No** _____

If yes, Why? _____ **What Medication(s)?** _____

All prescription medication sent to school must be in the same prescription container as put up by the pharmacist and must have the patients NAME, NAME OF MEDICATION, DOSAGE, AND DIRECTIONS on the label and a signed consent for dispense by parent!

VACCINATION: If your child is 12 years and older, have they been vaccinated against COVID-19? **YES NO**

IF yes, Date of 1st dose:_____**Date of 2nd dose:**_____ **If No,** Do you plan to get child vaccinated? **YES NO**

Medical Consent

I, _____Parent/Legal Guardian, authorize the following non-prescription Medication to be administered as needed for my child by the School Nurse, or designated RRCS personnel. **Please indicate with a check mark by the listed medications on which you are authorizing. Note* Benadryl will be given ONLY as a temporary relief for allergic reaction.

____ Acetaminophen	____ Antibiotic ointment	____ Cough Syrup
____ Cough Drops	____ Hydrocortisone Cream	____ Lip Balm
____ Eye drops/Lubricant	____ Emetrol (for Nausea)	____ Benadryl Cream
____ Ibuprofen	____ Antacid	____ Calamine/Caladryl
____ Oral Gel	____ Benadryl (Liquid)	____
____	____	

*If any child requires PHYSICIAN PRESCRIBED MEDICATION(s), will provide the original pharmacy container with the student's name, prescription, doctor's name and specific instructions. If any of the information must be changed, I will notify the school nurse or administrators in writing. I argue to and to hereby hold RRCS and its employees harmless from any all claims, demands, causes of action, liability or loss of any sort because of or arising out of acts or omissions with respect to this medication.

Parent/Guardian Signature: _____ Date: _____

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service
Health Services Administration
Chinle Comprehensive Health Care Facility
928-674-7179

Photocopy on white only. Will be scanned into patient chart.

Parent CONSENT FOR 2022-2023 SEASONAL FLU SHOT FOR SCHOOL STUDENTS

SCHOOL: _____

GRADE: _____ TEACHER: _____

The school flu clinic will be provided by Chinle Public Health Nursing (PHN). The **seasonal flu shot** is recommended annually for all school students. If you would like your child to receive their seasonal flu shot **at school** this year, please complete and **sign** this consent.

Only students with a signed consent will receive a seasonal flu shot at the school flu clinic.

INFORMATION ABOUT MY CHILD (Please print clearly)

Name: Last: _____ **First:** _____ **MI:** ____

Birth Date: _____ **Age:** _____ **Child's Gender: Male Female**

Health Care Facility Used: _____ **Child's Health Record #** _____

Child's Social Security # (last 4 digits only) _____

Parent/Guardian Name: _____ **Day Time Phone:** _____

Mailing Address: Box: _____ **Town:** _____ **State:** _____ **Zip:** _____

Physical Location of Home: _____

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1. **Is your child allergic to eggs? YES NO**
2. **Has your child ever had Guillain-Barre' Syndrome? YES NO**
3. **Has your child ever had a serious reaction to a flu shot? YES NO**

Please call the Chinle PHN Office at (928) 674-7179 if you have any questions about the school flu clinic, the seasonal flu, or the seasonal flu shot.

I certify that I am the parent or Legal Guardian of the child named above. I am legally authorized to request vaccination of the child with the seasonal flu vaccine. I have read the Vaccine Information Statement (see attached), about the seasonal flu and the seasonal flu vaccine. I, authorize a medical provider to assess my child, if needed, prior to my child's flu shot. I have had the opportunity to ask questions about the benefits and risks of the seasonal flu shot. My questions, if any, have been answered.

Parent/Guardian: _____ **Date:** _____

Please sign in black ink

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PUBLIC & INDIAN HEALTH SERVICE CONSENT FORM

CONSENT OF PARENT OR LEGAL GUARDIAN OR OTHER PERSON WITH PRIMARY RESPONSIBILITY FOR THE CARE OF THE CHILD

I /We _____ Parent(s) of _____
(Parent/Legal Guardian) (Student)

have read the Consent Form for the Public and Indian Health Service to arrange for or to provide the following health services for my child. (Please Check Mark√)

1. _____ Health care including medical examinations, sports physicals, screenings, routine laboratory studies, x-ray procedure, skin tests and routine immunizations.
2. _____ Dental Care including dental examinations, preventative use of flourides and necessary emergency dental care.
3. _____ Optometry care for eye examinations and eye glasses.
4. _____ Mental Health services include evaluation and treatment as necessary.
5. _____ Emergency Health Care for accident or illness.
6. _____ Transportation of child to and/or from another health facility for these services.
7. _____ Psychiatric services to include assessment, treatment, and medication as necessary.

PLEASE CHECK THE APPROPRIATE BOX(es):

☐ - I hereby give consent for all the above services.
☐ - Exceptions or Special Instructions: _____
☐ - I hereby give consent for reasonable cause and essential need to assure the health and safety of my child to ROUGH ROCK COMMUNITY SCHOOL staff while my child is in attendance.

Parent/Guardian Signature _____

Please Print Name: _____

Address: _____ City _____ Zip _____

Phone# _____ Alternate Phone# _____

Relationship _____

Date: _____ *Valid Until _____

Check the one that applies: ____ Enrolled in AHCCS, ____ - No Health Insurance

____ - Other Health Insurance, #_____

*Please be advised that ROUGH ROCK COMMUNITY SCHOOL staff will make every attempt to contact you before any of the above services are rendered. *This consent is only valid for one year from the date it was signed, a new one needs to be signed yearly.*

TEEN CLINIC HEALTH PERMIT 2022-2023

☐ Chinle HS ☐ MFHS ☐ Pinon HS ☐ RPHS
☐ Chinle Jr. HS ☐ RRHS ☐ PAMS ☐ RPCS

Name:_____
Census#:_____CHC#:_____ Grade:_____
DOB:_____ Birthplace:_____ Soc. Sec#:_____

School Attending:_____
_____

FAMILY CONTACT INFORMATION:

Mother's Name:_____ Maiden Name:_____
Mailing Address:_____ Home Phone#:_____
Home Location:_____
_____
Mother's Employer:_____ Work Phone#:_____

Father's Name:_____Home Phone#:_____
Home Location:_____
_____
Father's Employer:_____ Work Phone#:_____

If not with parents, where does student live?
_____
Person Responsible:_____
Relationship: _____
Contact Person#: (Home)_____ (Work)_____ (Cell)_____

Who should we contact if we cannot contact you?

1. Name:_____
   Relationship:_____
   Home Location:_____ Home Phone#:_____
   Employer:_____ Work Number#:_____

2. Name:_____
   Relationship:_____
   Home Location:_____ Home
   Phone#:_____
   Employer:_____ Work
   Number#:_____

INSURANCE INFORMATION: The Teen Clinic is part of Indian Health Services. Therefore, they will bill insurance and AHCCCS accordance with Indian Health Service policies.

Insurance Company
Name:_____
_____
Address:_____ Group
Number:_____
Employer or Group
Insured:_____
_____

IN CASE OF EMERGENCY: During school hours/activities. I give Permission for child to be transported to the doctor and give medical service deemed necessary by a licensed independent provider (MD, DO, NP, PA).

_____

Parent/Guardian/Self (if over 18 years) **Date**

NOTICE: THE SCHOOL DOES NOT TRANSPORT STUDENTS FOR ROUTINE CLINIC APPOINTMENTS OR MEDICAL PROBLEM(S) THAT ARE NOT EMERGENCIES.

Student's
Name:_____D.O.B:__
_____

HEALTH INFORMATION: Please list the following:

Any allergies to food or
medications?_____
_____

Recent injuries or
hospitalization?_____
_____

Any chronic
illnesses?_____
_____

Other health problems or concerns?_____

TEEN CLINIC CONSENT

The purpose of the School Base Health Clinic is to provide health care to teens that will enable them to be healthy and happy now and in the future. By providing care in the school setting, we hope to make health care easily available and to decrease absences from school. Appointments and referrals can be made through the school nurse's office or can be made through the hospital appointment system. Indian Health Service and other community agencies will provide health education, health promotion, health assessments and medical care. Service that may be available in the school include care for acute and chronic illness, physical examinations, immunizations, nutrition evaluation and education, mental health assessments and treatment, prenatal and postpartum care, family planning, fitness and healthy living counseling, and sports medicine.

1. I give permission for my child to receive health care at the Teen Clinic. I authorize the Chinle Hospital health care providers to test, render treatment as necessary and/or advisable for the evaluation and management for my child's health care.
2. I have indicated above any chronic illnesses, allergies and any bad reactions to medicine my child has had in the past.
3. If my child has not had a physical exam in the past year, I give permission for the Teen Clinic staff to do so.
4. If my child is 13 years of age or younger, **I will need to be present for annual physical exams or sports phsyicals.**

** Please note that a seperate consent form is required for immunizations.4**

Parents/Guardian/ Self (if over 18 of years) **Date** **Revised 04/2017**

The Smiles Movement

PO Box 767
Camp Verde, AZ 86322

Ph: 928-567-1832
Fax: 928-567-6500

thesmilesmovement@gmail.com

Please return this form to the school!

DEAR CONCERNED PARENT:

Dental disease is the #1 reason children miss school. The Smiles Movement has been providing care for your children for over 30 years at no charge to you. You have a choice; you can choose to go through the process at IHS, or enjoy the convenience of having our experienced doctors care for your child at their school. We thank you for once again choosing our practice that over the years has served thousands of children. To participate, your child must be enrolled in an appropriate AHCCCS program which is easily done at most IHS facilities.

IF YOU CHOOSE TO HAVE YOUR CHILD CONSIDERED FOR TREATMENT YOU MUST COMPLETE THE FOLLOWING:

Child's Name_____Male_____Female_____

Child's Social Security Number_____Date of Birth____/____/____

Emergency Contact_____Phone #_____

School Name_____Teacher's Name_____Grade_____

HEALTH HISTORY

PLEASE TELL US ABOUT YOUR CHILD'S HEALTH HISTORY. CHECK ALL OF THE FOLLOWING THAT APPLY TO YOUR CHILD:

Has your child had?	NO	YES
Allergy to medication	___	___
Rheumatic Fever	___	___
Psychiatric Treatment	___	___
Seizure Disorder	___	___
Diabetes	___	___
AIDS/HIV Positive	___	___
Hospitalizations	___	___
Vision or speech problems	___	___
Could your child be pregnant?	___	___

	NO	YES
Heart Murmur	___	___
Bleeding Disorders	___	___
High Blood Pressure	___	___
Asthma	___	___
Hepatitis/Jaundice	___	___
Anemia	___	___
Latex Allergy	___	___
Other Serious Illness	___	___

Is your child under a Physician's care? NO____YES____
Is your child taking any medication? ____ ____
Any problems with local anesthetic? ____ ____

PLEASE EXPLAIN ANY "YES" ANSWERS:_____

What is your primary concern for your child's oral health?_____

PLEASE TURN OVER AND COMPLETE

CONSENT FOR TREATMENT AND PATIENT MANAGEMENT

Following your child's examination, that consists of radiographs (x-rays) and in some cases, a panoramic scan, and cleaning, the doctor may determine that your child requires additional dental treatment, including silver fillings, routine baby tooth extractions, stainless steel crowns, and pulp treatments for deciduous (baby) teeth. These pulp treatments are routine procedures for baby teeth. More involved pulp treatments for permanent teeth (root canals) are referred.

The Smiles Movement dentists make all decisions very carefully, including referring your children who may benefit from sedation, protecting your child from injury with a gentle hand, or in the event of a critical situation, briefly using a papoose board similar to those used by physicians and hospitals. It is always our priority to give your child excellent dental care, protect them, and create a pleasant visit. These efforts will help insure positive dental experiences for a lifetime of smiles. If our dentists make the decision to refer your child, they take all factors into consideration, including the very limited number of general anesthesia appointments available at the IHS. We coordinate our schedules with the school nurse, and we welcome and encourage you to participate, however, we do understand that in some circumstances you cannot attend.

We have had great success with our program and we are looking forward to providing your child with excellent dental care. Participation in this program could affect future benefits your child may receive under private insurance or from another private dentist.

- **HELP US COMBAT DENTAL DISEASE, THE #1 CAUSE OF MISSED SCHOOL TIME**
- **WE WANT TO GIVE YOUR CHILD A SMILE THAT LASTS A LIFETIME**

CONSENT FOR TREATMENT AND AKNOWLEDGEMENT OF PRIVACY PRACTICES

By signing below I acknowledge that: (Please check one below)

1. _____ **YES. I give permission for my child to receive necessary treatment!**
   I am aware that I have rights outlined in the Notice of Privacy Practices and that a copy of this notice is available for my review.
   I consent to the sharing of this information with the IHS Dental program.

2. _____ **No. I do not want my child to receive necessary dental treatment provided at their school. I will assume responsibility for obtaining their treatment elsewhere.**

I understand that I may refuse to sign this Consent and Acknowledgement.

X_____**Date**_____

Parent or Guardian

Please print your name_____

If you have any questions, please call our office at 928-567-1832

PLEASE TURN OVER AND COMPLETE