Asthma:  □ YES  (higher risk for severe reaction) – refer to their asthma care plan  
□ NO  

◊ STEP 1: TREATMENT

SEVERE SYMPTOMS: Any of the following:
- LUNG: Short of breath, wheeze, repetitive cough
- THROAT: Tight, hoarse, trouble breathing/swallowing
- MOUTH: Swelling of the tongue and/or lips
- HEART: Pale, blue, faint, weak pulse, dizzy
- SKIN: Many hives over body, widespread redness
- GUT: Vomiting or diarrhea (if severe or combined with other symptoms)
- OTHER: Feeling something bad is about to happen, Confusion, agitation

MILD SYMPTOMS ONLY:
- NOSE: Itchy, runny nose, sneezing
- SKIN: A few hives, mild itch
- GUT: Mild nausea/discomfort

DOSAGE: Epinephrine: inject intramuscularly using auto injector (check one): □ 0.3 mg  □ 0.15 mg

☐ If symptoms do not improve ___ minutes or more, or symptoms return, 2nd dose of epinephrine should be given if available
- Antihistamine: (brand and dose)
- Asthma Rescue Inhaler (brand and dose)

Student has been instructed and is capable of carrying and self-administering own medication. ☐ Yes ☐ No

Provider (print) _______________________________ Phone Number: _______________________________

Provider’s Signature: ___________________________ Date: ___________________________

◊ STEP 2: EMERGENCY CALLS ◊

1. If epinephrine given, call 911. State that an anaphylactic reaction has been treated and additional epinephrine, oxygen, or other medications may be needed.

2. Parent: ___________________________ Phone Number: ___________________________

3. Emergency contacts: Name/Relationship ___________________________ Phone Number(s)
   a. ___________________________ 1) ___________________________ 2) ___________________________
   b. ___________________________ 1) ___________________________ 2) ___________________________

DO NOT HESITATE TO ADMINISTER EMERGENCY MEDICATIONS

I give permission for school personnel to share this information, follow this plan, administer medication and care for my child and, if necessary, contact our health care provider. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices and release the school and personnel from any liability in compliance with their Board of Education policies.

Parent/Guardian’s Signature: ___________________________ Date: ___________________________

School Nurse: ___________________________ Date: ___________________________
Staff trained and delegated to administer emergency medications in this plan:

1. 
2. 
3. 

Room 
Room 
Room 

Self-carry contract on file:  
Yes  
No

Expiration date of epinephrine auto injector: 

Keep the child lying on their back. If the child vomits or has trouble breathing, place child on his/her side.

AUVI-Q™ (EPINEPHRINE INJECTION, USP) DIRECTIONS

1. Remove the outer case of Auví-Q. This will automatically activate the voice instructions.
2. Pull off red safety guard.
3. Place black end against mid-outer thigh.
4. Press firmly and hold for 5 seconds.
5. Remove from thigh.

ADRENACLIK® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR DIRECTIONS

1. Remove the outer case.
2. Remove grey caps labeled “1” and “2”.
3. Place red rounded tip against mid-outer thigh.
4. Press down hard until needle enters thigh.
5. Hold in place for 10 seconds. Remove from thigh.

EPIPEN® AUTO-INJECTOR DIRECTIONS

1. Remove the EpiPen Auto-Injector from the clear carrier tube.
2. Remove the blue safety release by pulling straight up without bending or twisting it.
3. Swing and firmly push orange tip against mid-outer thigh until it ‘clicks’.
4. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove auto-injector from the thigh and massage the injection area for 10 seconds.

If this conditions warrents meal accommodations from food service, please complete the form for dietary disabilitiy if required by district policy.

Additional information:

Adopted from the Allergy and Anaphylaxis Emergency Plan provided by the American Academy of Pediatrics, 2017

January 2018
COLORADO ASTHMA CARE PLAN AND MEDICATION ORDER FOR SCHOOL AND CHILD CARE SETTING

PARENT/GUARDIAN COMPLETE, SIGN AND DATE:

Child Name: __________________________ Birthdate: ____________
School: ___________________________ Grade: ____________
Parent/Guardian Name: __________________________ Phone: ____________

I approve this care plan and give permission for school personnel to share this information, follow this plan, administer medication and care for my child/youth, and if necessary, contact our health care provider. I assume responsibility for providing the school/program prescribed, non-expired medication and supplies (such as a spacer), and to comply with board policies, if applicable. I am aware 911 may be called if a quick relief inhaler is not at school and my child/youth is experiencing symptoms.

Parent/Guardian Signature __________________________ Date ____________

HEALTH CARE PROVIDER COMPLETE ALL ITEMS, SIGN AND DATE:

QUICK RELIEF MEDICATION: ☐ Albuterol ☐ Other: __________________________
Common side effects: ↑ heart rate, tremor ☐ Use spacer with inhaler (MDI)
Controller medication used at home: __________________________
TRIGGERS: ☐ Weather ☐ Illness ☐ Exercise ☐ Smoke ☐ Dust ☐ Pollen ☐ Poor Air Quality ☐ Other: __________________________
☐ Life threatening allergy specify: __________________________

QUICK RELIEF INHALER ADMINISTRATION: With assistance or self-carry.
☐ Student needs supervision or assistance to use inhaler. Student will not self-carry inhaler.
☐ Student understands proper use of asthma medications, and in my opinion, can self-carry and use his/her inhaler at school independently with approval from school nurse and completion of contract.

IF YOU SEE THIS: | DO THIS:
---|---
GREEN ZONE: No Symptoms | PRETREATMENT FOR STRENUOUS ACTIVITY, please choose ONE:
• No current symptoms | ☐ Not required OR ☐ Student/Parent request OR ☐ Routinely
• Strenuous activity planned | Give QUICK RELIEF MED 10-15 minutes before activity: ☐ 2 puffs ☐ 4 puffs

YELLOW ZONE: Mild symptoms |
• Trouble breathing | 1. Give QUICK RELIEF MED: ☐ 2 puffs ☐ 4 puffs
| • Wheezing | 2. Stay with child/youth and maintain sitting position.
| • Frequent cough | 3. REPEAT QUICK RELIEF MED if not improving in 15 minutes: ☐ 2 puffs ☐ 4 puffs
| • Chest tightness | If symptoms do not improve or worsen, follow RED ZONE.
| • Not able to do activities | 4. Child/youth may go back to normal activities, once symptoms are relieved.

RED ZONE: EMERGENCY | 5. Notify parents/guardians and school nurse.
• Coughs constantly | 1. Give QUICK RELIEF MED: ☐ 2 puffs ☐ 4 puffs
| • Struggles to breathe | Refer to the anaphylaxis care plan if the student has a life threatening allergy. If there is no anaphylaxis care plan follow emergency guidelines for anaphylaxis.
| • Trouble talking (only speaks 3-5 words) | 2. Call 911 and inform EMS the reason for the call.
| • Skin of chest and/or neck pull in with breathing | 3. REPEAT QUICK RELIEF MED if not improving: ☐ 2 puffs ☐ 4 puffs
| • Lips/fingernails gray/blue | Can repeat every 5-15 minutes until EMS arrives.

Health Care Provider Signature __________________________ Print Provider Name __________________________ Date ____________

Fax __________________________ Phone __________________________ Email __________________________

School Nurse/CCHC Signature __________________________ Date ____________

☐ Self-carry contract on file. ☐ Anaphylaxis plan on file for life threatening allergy to: __________________________

*Including reactive Airways, exercise-induced bronchospasm, twitchy airways.
Immunization
Certificate of Medical Exemption

Colorado law C.R.S. § 25-4-902 requires all students attending any school in the state of Colorado to be vaccinated against certain vaccine-preventable diseases, as established by Colorado Board of Health rule 6 CCR 1009-2, unless an exemption is filed. This law applies to students attending public, private and parochial kindergarten, elementary and secondary schools through 12th grade, colleges or universities, and child care facilities licensed by the Colorado Department of Human Services including child care centers, school-age child care centers, preschools, day camps, resident camps, day treatment centers, family child care homes, foster care homes, and Head Start programs. Students with a recorded immunization exemption may be kept out of a child care facility or school during a disease outbreak; the length of time will vary depending on the type of the disease and the circumstances of the outbreak. Medical exemptions need to be filed only once unless the student’s information or school changes.

Please complete all required fields below and obtain all required signatures; incomplete forms will not be accepted.

Student Information:

Last Name:  
First Name:  
Middle Name:  

Date of Birth:  
Sex:  □ Female  □ Male  □ X

Parent/Guardian Completing This Form:

Check if an emancipated student or student over 18 years old:  □

Last Name:  
First Name:  
Middle Name:  

Relationship to student:  □ Mother  □ Father  □ Legal Guardian

School/Licensed Child Care Facility Information:

School Name/Licensed Child Care Facility:

School District:  
Address:

City:  
State:  
Zip Code:  

Required Vaccines for School Entry:

Check each vaccine declined:  
List medical contraindication(s) for each vaccine declined:

□ Hepatitis B
□ Diphtheria, tetanus, pertussis (DTaP, Tdap)
□ Haemophilus influenzae type b (Hib)
□ Inactivated poliovirus (IPV)
□ Pneumococcal conjugate (PCV13)
□ Measles, mumps, rubella (MMR)
□ Varicella (chickenpox)

Statement of Exemption

The physical condition of the above named student is such that vaccination would endanger their life or health or is medically contraindicated due to other medical conditions. The information I have provided on this form is complete and accurate.

REQUIRED Signature:  
Date:  
Physician (MD, DO), Advanced Practice Nurse (APN), or Physician Assistant (authorized pursuant to section 12-240-107 (6), C.R.S.)

REQUIRED:  
Professional License Number:  
(State/Territory)

Under Colorado law, you have the option to exclude your child's/your information from the Colorado Immunization Information System (CIIS). To opt out of CIIS, go to: www.colorado.gov/cdphe/ciis-opt-out-procedures. Please be advised that you will be responsible for maintaining your child’s/your immunization records to ensure school compliance.

Last Reviewed August 2021
Immunization Certificate of Nonmedical Exemption

Colorado law C.R.S. § 25-4-902 requires all students attending any school in the state of Colorado to be vaccinated against certain vaccine-preventable diseases, as established by Colorado Board of Health rule 6 CCR 1009-2, unless an exemption is filed. This law applies to students attending public, private and parochial kindergarten, elementary and secondary schools through 12th grade, colleges or universities, and child care facilities licensed by the Colorado Department of Human Services including child care centers, school-age child care centers, preschools, day camps, resident camps, day treatment centers, family child care homes, foster care homes, and Head Start programs. "Nonmedical exemption" means an immunization exemption based upon a religious belief whose teachings are opposed to immunizations or a personal belief that is opposed to immunizations. Prior to kindergarten, a nonmedical exemption must be filed each time a student is due for vaccines according to the schedule developed by the ACIP. 1,2 From kindergarten through 12th grade, a nonmedical exemption must be filed every year during the student's school enrollment/registration process. 1 Students with a recorded immunization exemption may be kept out of a child care facility or school during a disease outbreak; the length of time will vary depending on the type of the disease and the circumstances of the outbreak.

Please complete all required fields below and obtain all required signatures; incomplete forms will not be accepted.

<table>
<thead>
<tr>
<th>Student Information:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Name:</td>
</tr>
<tr>
<td>First Name:</td>
</tr>
<tr>
<td>Middle Name:</td>
</tr>
<tr>
<td>Date of Birth:</td>
</tr>
<tr>
<td>Sex: ☐ Female ☐ Male ☐ X</td>
</tr>
<tr>
<td>Parent/Guardian Completing This Form: ☐ Check if an emancipated student or student over 18 years old</td>
</tr>
<tr>
<td>Last Name:</td>
</tr>
<tr>
<td>First Name:</td>
</tr>
<tr>
<td>Middle Name:</td>
</tr>
<tr>
<td>Relationship to student: ☐ Mother ☐ Father ☐ Legal Guardian</td>
</tr>
<tr>
<td>School/Licensed Child Care Facility Information:</td>
</tr>
<tr>
<td>School Name/Licensed Child Care Facility:</td>
</tr>
<tr>
<td>School District:</td>
</tr>
<tr>
<td>☐ Check if Not Applicable</td>
</tr>
<tr>
<td>Address:</td>
</tr>
<tr>
<td>City:</td>
</tr>
<tr>
<td>State:</td>
</tr>
<tr>
<td>Zip Code:</td>
</tr>
</tbody>
</table>

Required Vaccines for School Entry - Place an “X” next to each vaccine for which you are claiming a nonmedical exemption.

- Diphtheria, tetanus, pertussis (DTP) [X]
- Tetanus, diphtheria, pertussis (Tdap)
- Inactivated poliovirus (IPV) [X]
- Haemophilus influenzae type b (Hib)
- Inactivated poliovirus (IPV)
- Measles, mumps, rubella (MMR)
- Pneumococcal conjugate (PCV13)
- Varicella (chickenpox)

Statement of Exemption

I am the parent/guardian of the above-named student or am the student themself (emancipated or over 18 years of age) and am claiming a nonmedical exemption from the vaccine(s) indicated above. The information I have provided on this form is complete and accurate. I can review evidence-based vaccine information at www.colorado.gov/cdphe/immunization-education, www.spreadthewaxfacts.com/, www.immunizeForGood.com/ for additional information on the benefits and risks of vaccines and the diseases they prevent. I can contact the Colorado Immunization Information System (CIIS) at www.covaxrecords.org or my health care provider to locate my child’s/my immunization record.3

REQUIRED Signature: ____________________________ Date: ______________
Parent/Legal Guardian/Student (emancipated or over 18 years old)

REQUIRED Provider Signature Section:

REQUIRED Print Name, Title, and Signature: ____________________________ Date: ______________
Physician (MD, DO), Advanced Practice Nurse (APN), Physician Assistant, Registered Nurse (RN) or Pharmacist (authorized pursuant to section 12-240-107 (6), C.R.S.)

REQUIRED Colorado Professional License Number: ____________________________

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1 Colorado Board of Health rule 6 CCR 1009-2: https://www.sos.state.co.us/CCR/GenerateRulePdf.do?ruleVersionId=76988&fileName=6%20CCR%201009-2

2 2021 Recommended Immunizations from Birth through 6 Years Old: www.cdc.gov/vaccines/priority-lists/rec-vac-sched-0-6-yr-olds.pdf. Based on this schedule, a nonmedical exemption would be submitted at 2 months, 4 months, 6 months, 12 months and 18 months of age.

3 Under Colorado law, you have the option to exclude your child’s/your information from CIIS at any time. To opt out of CIIS, go to www.colorado.gov/cdphe/cisis-opt-out-procedures. Please be advised you will be responsible for maintaining your child’s/your immunization records to ensure school compliance.
Medication Administration Permission for School and Child Care

The parent/guardian of _____________________________ ask that school/child care staff give the following medication _____________________________ at ____________________________ to my child, according to the Health Care Provider’s signed instructions on the lower part of this form.

Prescription medications must come in a container labeled with: child’s name, name of medicine, time medicine is to be given, dosage, date medicine is to be stopped, and licensed health care provider’s name. Pharmacy name and phone number must also be included on the label.

Over the counter medication must be labeled with child’s name. Dosage must match the signed health care provider authorization, and medicine must be packaged in original container.

The Program agrees to administer medication prescribed by a licensed health care provider with prescriptive authority. The parent agrees to pick up expired or unused medication within one week of notification by staff. All medication(s) that are left at the school will be discarded according to the most current state regulatory recommendations for safe medication disposal.

By signing this document, I give permission for my child’s health care provider to share information about the administration of this medication with the nurse or school staff delegated to administer medication.

Parent/Legal Guardian’s Name ____________________________ Parent/Legal Guardian Signature ____________________________ Date ____________

Work Phone ____________________________________________ Home Phone ____________________________________________

Health Care Provider Authorization

Child’s Name: ____________________________ Birthdate: ____________________________

Medication: ____________________________ Dosage: ____________________________ Route ____________________________

To be given at the following time(s): ____________________________ Special Instructions: ____________________________

Purpose of medication: ____________________________ Side effects to be reported: ____________________________

Starting Date: ____________________________ Ending Date: ____________________________

Signature of Health Care Provider with Prescriptive Authority ____________________________ Date ____________________________

Print Name of Health Care Provider ____________________________

School Nurse or Child Care Health Consultant signature ____________________________ Date ____________________________

Self-Carry Medication Administration Contract

<table>
<thead>
<tr>
<th>Student Name:</th>
<th>School:</th>
<th>School Year:</th>
<th>Grade:</th>
</tr>
</thead>
</table>

Colorado law does allow responsible students to carry and self-administer their rescue inhaler and/or epinephrine auto-injector (C.R.S.22-1-119.5). In 2012, the law was extended to prescription medication. This law (C.R.S 22-1-119.3) allows the student to carry sufficient medication for a single day or for the duration of the event with approval of provider, parent and administrator. ([CDE Medication Administration Guidelines - 2019](http://example.com)).

Students/Families:
1. Self-carrying and administering any medication in the school setting is a privilege and must be kept in their own possession at all times in the original container.
2. At no time should any medication be shared with anyone else.

Failure to comply with either of these rules may result in loss of privilege to self-carry and administer. If privileges are revoked, the School Nurse will discuss with the Health Services administrative team and the decision will be communicated to parents and medical provider; and a new plan of care will be developed.

### Criteria to be met when self-carry and self-administering (Nurse check off boxes when reviewed with student/family):

- Student is self-directed and knowledgeable about their condition and medication.
- Severity of health condition warrants carrying and self-administration.
- The student demonstrates the ability to self-administer medication properly.
- Student is confirmed to be responsible and mature enough to carry medication.
- Written authorization is obtained from the parent and medical provider.
- Nurse is able to monitor the self-administration process and document 2x/year in Infinite Campus with the student. Nurse will check the expiration date on the medication when checking in with the student.
- Student has an order from their medical provider and parent/legal guardian signature permission to self-carry/administer.
- Nurse notifies students’ teachers about the student’s condition and that the student is able to self-carry and administer their own medication.
- Student is directed to notify the health aide when the medication was administered if inhaler/epi pen.

### Medication self-carried/administered:

- Epi-pen - allergies
- Inhaler - asthma
- OTC oral pills (essential oils/herbs/vitamins)
- Prescriptive oral pills
- Topical cream/ointment (ears/eyes)

Diabetes insulin or other treatments for Diabetes 1 and 2 are covered on the Diabetes orders and Individualized Student Health Plan (ISHP).

<table>
<thead>
<tr>
<th>Student Signature:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>RN name:</th>
<th>RN Signature:</th>
<th>Date:</th>
</tr>
</thead>
</table>

_DHS July 2021_
Parent/Guardian Approval
Return to School Day Activities Following A Concussion

Date: __________________ School: __________________

School Site Health Aide: _____________________________

Student: _____________________________

Dear Parent/Guardian,

Your child was placed on concussion protocol on ___________. Your child is no longer exhibiting any signs/symptoms of a concussion and no longer is in need of academic adjustments. We encourage you to have your child evaluated by a medical provider to confirm the resolution of the injury. In order to remove your child from the concussion protocol and return to all school-day physical activities we will need the following:

A release from a medical provider OR sign this form acknowledging you agree and have completed the Gradual Return to Play multi-day process below.

By signing this form, I acknowledge the following:
- I am aware of the seriousness of a concussion.
- I acknowledge that it is best practice to have my child evaluated by a medical provider for medical clearance following a concussion.
- I recognize that allowing my student to prematurely participate in physical activity that poses a risk of repeat head injury could result in a secondary head injury (second impact syndrome).
- My student is no longer displaying any concussion symptoms at home.
- I approve of my child to return to all school day activities including PE, recess, and/or all other organized/unorganized physical school activities.
- My student has completed a gradual return to activity at home, as outlined in the table below:

Graduated Return-to-Sport (RTS) Strategy Recommended by The 2016 Berlin Consensus Statement on Concussion in Sport

<table>
<thead>
<tr>
<th>Stage</th>
<th>Activity</th>
<th>Goal of Each Step</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Symptom-limited activity</td>
<td>Daily activities that do not provoke symptoms</td>
</tr>
<tr>
<td>2</td>
<td>Light aerobic exercise</td>
<td>Walking or stationary cycling at slow to medium pace. No resistance training</td>
</tr>
<tr>
<td>3</td>
<td>Sport-specific exercise</td>
<td>Running or skating drills. No head impact activities</td>
</tr>
<tr>
<td>4</td>
<td>Non-contact training drills</td>
<td>Harder training drills, e.g. passing drills. May start progressive resistance training</td>
</tr>
<tr>
<td>5</td>
<td>Full contact practice</td>
<td>Following medical clearance, participate in normal training activities</td>
</tr>
<tr>
<td>6</td>
<td>Return to sport</td>
<td>Normal game play</td>
</tr>
</tbody>
</table>

Instructions: Gradual return to play indicates progression through stages 1-6 while monitoring for symptoms. Begin at stage 1. There should be at least 24 hours between each step of the progression. If any symptoms worsen during the exercise, the student should go back to the previous step. Adhering to these steps is best practice when returning any person with a concussion back to a recreational sport/activity. Please contact your district nurse with any questions.

__________________________
Parent/Guardian Print Name

__________________________
Parent/Guardian signature

__________________________
Date

DHS 11/2023
# Student Health Information

School Year: 

**Student Name:** 
**Birthday:** 
**Grade:** 
**School:** 

<table>
<thead>
<tr>
<th>Health Concerns</th>
<th>Yes</th>
<th>No</th>
<th>Medication (Name, Dosage)</th>
<th>Necessary Monitoring in School</th>
<th>Comments or Describe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma/Respiratory</td>
<td></td>
<td></td>
<td>Food, Latex, Insects, Nuts</td>
<td>type of reaction</td>
<td></td>
</tr>
<tr>
<td>Severe Allergies</td>
<td></td>
<td></td>
<td></td>
<td>date of last reaction:</td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
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<td></td>
<td>Equipment:</td>
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<tr>
<td>Head Injury</td>
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<tr>
<td>Seizures/Neurological/ Migraines</td>
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<td></td>
<td></td>
<td>Type &amp; date of last episode</td>
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<tr>
<td>Heart/Blood</td>
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<tr>
<td>Muscles/Bones/Joints/Skin</td>
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<tr>
<td>Bladder/Kidney</td>
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<td>Stomach/Intestines/Bowels</td>
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<tr>
<td>Immune Problems</td>
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<tr>
<td>Other Health Concerns</td>
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<tr>
<td>Hearing Concerns</td>
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<td>Hearing aids?, Preferential seating?</td>
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<tr>
<td>Vision Concerns</td>
<td></td>
<td></td>
<td>Glasses or contacts?, Reading only?</td>
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<tr>
<td>Growth &amp; Nutritional Concerns</td>
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<tr>
<td>Developmental Concerns</td>
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<tr>
<td>Emotional/Behaviorial</td>
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</tbody>
</table>

- Routine or daily medications, treatments or therapies (not listed above): 
- Activity restrictions in school? 
- Special medical equipment required in school? (e.g., oxygen, wheelchair) 
- Have there been any significant changes in your child's health over the last year? Explain: 
- ILLNESSES, HOSPITALIZATIONS, ACCIDENTS/INJURIES and dates: (use other side if necessary)

Health Care Provider(s) & Phone #: 

**Parent/Guardian Signature:** ____________________________ **Home/Work Phone #** ____________________________ **Date completed:** ____________________________

Name of school nurse: ____________________________ your school nurse can be reached at: ____________________________

Please contact the school nurse directly if you would like to discuss any of the above information that you feel is confidential.