AFTER SCHOOL ROUTINE

Your child's safety after school is very important to us! Please fill out this form with your child's daily routine. If your child will be picked up by someone other than a parent, please include this information at the bottom of the page. Please remember that your child will be released to only those noted on this sheet unless prior notification is given to the front office. Please remember, if there are any changes to your child's daily routine you need to call the main office at 303-646-1858 no later than 2pm to ensure your child receives the change of plans.

Your child's daily routine will be followed, even in the event of an emergency school closure, unless we receive direct communication from you.

My Child is to:

RIDE BUS # _____ KID'S CLUB YES NO

PARENT PICK-UP YES NO

Parent's home phone_____

Mom's work/cell phone _____Dad's work/cell phone _____

Mom's E-mail _____Dad's E-mail _____

AUTHORIZED ADDITIONAL PICK-UP

NAME_____ Relationship _____

NAME_____ Relationship _____

STUDENT'S NAME_____

TEACHER_____

GRADE_____

OTHER SIBLINGS IN SCHOOL _____

_____

Parent or Guardian Signature Date

Elizabeth SCHOOL DISTRICT

Student Health Information Form

20_____ - 20_____

Student Name: _____ Birth Date:_____ School: _____ Grade:_____

Will your student be riding a bus this school year? Yes_____ No_____

Will your student be participating in school sponsored after school activities this school year (sports, clubs, before/after care)? Yes ___ No ____ If yes, which activities: _____

Does your student have any non-life threatening allergies? Yes_____ No_____

If yes, please list the allergies, reactions, and how you treat at home:

_____

_____

Please list current medications your child is taking routinely at home (prescribed, over the counter, and supplements):

_____

_____

Will medication need to be given at school? *Yes_____ No_____

If yes, list medication(s): _____

"Permission to Give Prescription/Homeopathic Medications at School" form is required to be signed by the health care provider and the parent/guardian. Medication cannot be given until consents have been received

CHECK THE CONCERNS(S) YOUR CHILD HAS BELOW, OR (initial)_____ MY CHILD HAS NO KNOWN HEALTH CONDITIONS

(You may stop here if there are no known medical conditions. Please sign on page 2 and return form).

___ Accidents/Injuries	___ Cerebral Palsy	___ Hearing loss or aids	___ **Migraines/Headaches** (See below)
___ **ADD/ADHD** (See below)	___ Crohn's Disease/IBS	___ Head Injury/Concussion	___ Neuromuscular Disease
___ **Allergies, Severe** (See below)	___ Cystic Fibrosis	Date Diagnosed:_____	___ Orthopedic Disability
___ Allergies, seasonal	___ **Diabetes** (See below)	___ Heart Conditions	___ Daily Oxygen use **(requires provider order)**
___ **Asthma** (See below)	___ Down Syndrome	Type:_____	___ Renal/Kidney/Bladder
___ Autism	___ **Epilepsy/Seizures** (See below)	___ Hemophilia/Bleeding Disorder	___ Skin Conditions
___ Behavior Concerns	___ Gastric Reflux/Ulcers	___ Immune Conditions	___ Stomach/Intestines
___ Cancer/Leukemia	___ Glasses/Contacts	___ **Mental Health Diagnosis** (See below)	___ Tracheostomy
Date Diagnosed: _____	___ G-Tube or other type of feeding tube **(requires tube feed authorization form)**		___ Other: _____
Treatment Status: _____			
___ Developmental Delays			

Further details(s) if needed:

_____

_____

_____

_____

FOR THE FOLLOWING CONDITIONS, PLEASE PROVIDE ADDITIONAL INFORMATION (Additional conditions on back)

Severe Allergies Notify Nurse immediately if anaphylaxis may occur.	What is your child allergic to? _____ Is medication needed at school for allergies? Yes____ No ____ If yes, name: _____ Location of Medication: Carried by student (**requires self-carry form**) _____ or Health Office (**requires anaphylaxis action plan**) _____ Date last reaction: _____ Type of reaction (difficulty breathing, hives etc.):_____

Asthma	Is medication needed at school for asthma? Yes____ No____ If yes, name:_____ Location of Medication: Carried by student (**requires self-carry form**) _____ or Health Office (**requires CO asthma action plan**) _____ Date of last episode: _____ Triggers (exercise etc.): _____
Epilepsy/Seizures	Type:_____ Date of last seizure: _____ Is emergency medication needed at school? *Yes____ No _____ If yes, name:_____ ***Requires Seizure Action Plan***
Diabetes	Type I _____ Type II _____ Date of diagnosis: _____ Insulin by: Pump (list type) _____ Injections _____ Pen _____ CGM: Yes (list type) _____ No _____ Type of rescue medication (Baqsimi, glucagon etc.): _____ Is your student independently managing? Yes (**requires Self-Management Plan**) _____ No _____ **Please call to schedule conference with District Nurse – notify immediately if newly diagnosed.**
ADD/ADHD Mental Health	ADD _____ ADHD _____ Anxiety _____ Depression _____ Other: _____ Is medication needed at school? *Yes_____ No _____ If yes, name: _____ ***Requires Permission to Give Meds at School Form***
Migraine/ Headaches	How often does your child experience migraines: _____ Triggers/aura: _____ Is medication needed at school? *Yes _____ No _____ If yes, name: _____ ***Requires provider orders or headache/migraine action plan***

Is there anything else you would like for us to know to better care for your child?

_____

_____

_____

_____

_____

Parent/Guardian Signature _____

Contact Phone # _____

Date _____

The following forms can be found on the Elizabeth School District Health page:

1. Permission to Give Prescription/Homeopathic Medications at School
2. Allergy and Anaphylaxis Action Plan &
    a. Self-Carry Agreement **(Middle and High School Students only)**
3. Asthma Action Plan &
    a. Self-Carry Agreement **(Middle and High School Students only)**
4. Tube Feeding Authorization Form
5. Seizure Action Plan
6. Permission for Nursing Procedure

Please contact the District Nurse if you would like to discuss any of the above information (303-646-6730)