

# SAMPLE

Appendix AA

## ACADEMIC INTERVENTION PLAN

Name \_\_\_\_\_ School Year \_\_\_\_\_

Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_

The following areas that foster academic success for the student must be described in detail. If a particular area listed does not apply, enter "Not Applicable" next to the area. The completed plan is attached to the student's report card and filed in the student's academic file. This plan must be reviewed and modified, if necessary, on a quarterly basis. Designated signatures as indicated at the bottom are to be included as part of the finalized plan.

- Curriculum Modifications
- Support Services
- Environmental Accommodations
- Lesson Accommodations
- Modified Assignments
- Organization and Study Skills
- Other

Required signatures:

- Parent(s) \_\_\_\_\_ Date \_\_\_\_\_
- Teacher(s) \_\_\_\_\_ Date \_\_\_\_\_
- Principal \_\_\_\_\_ Date \_\_\_\_\_

OFFICE OF CATHOLIC SCHOOLS DIOCESE OF ARLINGTON  
DIABETES MEDICAL MANAGEMENT PLAN

Page 1 of 5

**PART I TO BE COMPLETED BY PARENT OR GUARDIAN**

Student \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date of Diagnosis \_\_\_\_\_

School \_\_\_\_\_ Grade/ Teacher \_\_\_\_\_

Physical Condition: *check all that apply* Diabetes type 1 Diabetes type 2

**Contact Information**

**Mother/Guardian:** \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

**Father/Guardian:** \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

**Licensed Health Care Provider:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax \_\_\_\_\_ Emergency \_\_\_\_\_

**Emergency Contacts:**

Name: \_\_\_\_\_ Relationship \_\_\_\_\_

Telephone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

**Notify parents/guardian or emergency contact in the following situations:**

Blood glucose less than \_\_\_\_\_ mg/dl

Blood glucose greater than \_\_\_\_\_ mg/dl

Insulin pump problems

Vomiting or feeling ill

Presence of urine ketones

Other: \_\_\_\_\_

**PART II TO BE COMPLETED BY LICENSED HEALTH CARE PROFESSIONAL**

**BLOOD GLUCOSE MONITORING**

Type of blood glucose meter student uses: \_\_\_\_\_

Target range for blood glucose is 70-150 70-180 Other \_\_\_\_\_

Usual times to check blood glucose \_\_\_\_\_

**(Blood Glucose Monitoring continued)**

Times to do extra blood glucose checks (*check all that apply*)

Before exercise

After exercise

When student exhibits symptoms of hyperglycemia

When student exhibits symptoms of hypoglycemia

Other (explain): \_\_\_\_\_

Can student perform own blood glucose checks?    Yes                      No

Exceptions: \_\_\_\_\_

Student may test discreetly in the classroom setting    Yes    No

Student must test in the school health room                      Yes    No

Type of blood glucose meter student uses: \_\_\_\_\_

**Blood glucose Management**

Refer to appropriate treatments as indicated on Parts A and B Quick Reference Emergency Plan

**FOR STUDENTS TAKING ORAL DIABETES MEDICATIONS**

Type of medication: \_\_\_\_\_ Timing: \_\_\_\_\_

Other medications: \_\_\_\_\_ Timing: \_\_\_\_\_

**INSULIN**

*Administration of insulin during school-sanctioned activities requires complete, appropriate, Medication Authorization forms.*

**Usual Lunchtime Dose**

Base dose of, (*select appropriate type*)

<b>Regular</b>	insulin is _____ Units.	<b>Intermediate</b>	insulin is _____ Units.	<b>Basal</b>	insulin is _____ Units.
<b>Novolog</b>	insulin is _____ Units.	<b>NPH</b>	insulin is _____ Units.	<b>Lantus</b>	insulin is _____ Units.
<b>Humalog</b>	insulin is _____ Units.	<b>Lente</b>	insulin is _____ Units.	<b>Ultralente</b>	insulin is _____ Units.

**Insulin Correction Doses**

Parental authorization required before administering a correction dose for high blood glucose levels.

Yes    No

- \_\_\_\_\_ units if blood glucose is \_\_\_\_\_ to \_\_\_\_\_ mg/dl
- \_\_\_\_\_ units if blood glucose is \_\_\_\_\_ to \_\_\_\_\_ mg/dl
- \_\_\_\_\_ units if blood glucose is \_\_\_\_\_ to \_\_\_\_\_ mg/dl
- \_\_\_\_\_ units if blood glucose is \_\_\_\_\_ to \_\_\_\_\_ mg/dl
- \_\_\_\_\_ units if blood glucose is \_\_\_\_\_ to \_\_\_\_\_ mg/dl

Can student give own injections?                      Yes                      No

Can student determine correct amount of insulin?    Yes                      No

Can student draw correct dose of insulin?                      Yes                      No

Parents are authorized to adjust the insulin dosage under the following circumstances \_\_\_\_\_

\_\_\_\_\_

**FOR STUDENTS WITH INSULIN PENS**

Type of pen: \_\_\_\_\_

Insulin / carbohydrate ratio: \_\_\_\_\_

Correction factor: \_\_\_\_\_

Special instructions, if any: \_\_\_\_\_  
 \_\_\_\_\_

**FOR STUDENTS WITH INSULIN PUMPS**

Type of pump: \_\_\_\_\_

Basal rates: \_\_\_\_\_ 12 am to \_\_\_\_\_

\_\_\_\_\_ to \_\_\_\_\_

\_\_\_\_\_ to \_\_\_\_\_

Type of insulin in pump: \_\_\_\_\_

Type of infusion set: \_\_\_\_\_

Insulin/carbohydrate ratio: \_\_\_\_\_

Correction factor: \_\_\_\_\_

Special instructions if any: \_\_\_\_\_  
 \_\_\_\_\_

***Student Pump Abilities/Skills***

- Count carbohydrates
- Bolus correct amount for carbohydrates consumed
- Calculate and administer corrective bolus
- Calculate and set basal profiles
- Calculate and set temporary basal rate
- Disconnect pump
- Reconnect pump at infusion set
- Prepare reservoir and tubing
- Insert infusion set
- Troubleshoot alarms and malfunctions

***Needs Assistance***

- |     |    |
|-----|----|
| Yes | No |
| Yes | No |
| Yes | No |
| Yes | No |
| Yes | No |
| Yes | No |
| Yes | No |
| Yes | No |
| Yes | No |
| Yes | No |

**MEALS AND SNACKS EATEN AT SCHOOL**

Is student independent in carbohydrate calculations and management? Yes No

***Meal/Snack***

***Time***

***Food content/amount***

Breakfast	_____	_____
Mid-morning snack	_____	_____
Lunch	_____	_____
Mid-afternoon snack	_____	_____
Dinner	_____	_____

Snack before exercise? Yes No

Snack after exercise? Yes No

Other times to give snacks and content/amount: \_\_\_\_\_

Preferred snack foods: \_\_\_\_\_

Foods to avoid, if any: \_\_\_\_\_

Instructions for when food is provided to the class (e.g., as part of a class party or food sampling event):

\_\_\_\_\_  
 \_\_\_\_\_

**EXERCISE AND SPORTS**

Check blood glucose levels prior to PE/activity Yes No  
Student should **not** exercise if blood glucose level is below \_\_\_\_\_ mg/dl or above \_\_\_\_\_ mg/dl  
or if moderate to large urine ketones are present.

Student will carry a fast-acting carbohydrate such as \_\_\_\_\_ to the site of exercise.

Restrictions on activity, if any: \_\_\_\_\_

Other considerations: \_\_\_\_\_

**HYPOGLYCEMIA (Low Blood Sugar)**

**Complete Part A of Diabetes Medical Management Plan**

Usual symptoms of hypoglycemia: \_\_\_\_\_

Treatment of hypoglycemia: \_\_\_\_\_  
\_\_\_\_\_

**GLUCAGON**

*Administration of Glucagon during school-sanctioned activities requires complete appropriate Medication Authorization forms.*

Glucagon is to be given if the student is unconscious, having a seizure (convulsion), or unable to swallow.

Route \_\_\_\_\_ Dosage \_\_\_\_\_ Site: arm thigh other.

**If Glucagon is required, administer it promptly. Call 911 and the parents/guardian.**

**HYPERGLYCEMIA (High Blood Sugar)**

**Complete Part B of Diabetes Medical Management Plan**

Usual symptoms of hyperglycemia: \_\_\_\_\_

Treatment of hyperglycemia: \_\_\_\_\_

Urine should be checked for ketones when blood glucose levels are above \_\_\_\_\_ mg/dl.

Treatment for ketones: \_\_\_\_\_

**DISASTER PLANNING**

Special considerations, if any

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**OTHER CONSIDERATIONS FOR THE PLAN**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PARENTAL PROVIDED SUPPLIES TO BE KEPT AT SCHOOL**

- Blood glucose meter and test strips
- Batteries for meter
- Lancet device and lancets
- Urine ketone strips
- Insulin vials and syringes
- Insulin pump
- Batteries for pump
- Infusion set and supplies
- Insulin pen, pen needles, insulin cartridges
- Fast-acting source of glucose
- Carbohydrate containing snack
- Glucagon emergency kit
- 3 days supply of food and drink (disaster preparedness)

**Signatures**

**This Diabetes Medical Management Plan has been formulated and approved by:**

\_\_\_\_\_  
 Licensed Health Care Provider Telephone \_\_\_\_\_ Date \_\_\_\_\_

I give permission to the school nurse, trained diabetes personnel, and other designated staff members of \_\_\_\_\_ School to perform and carry out the diabetes care tasks as outlined by \_\_\_\_\_'s Diabetes Medical Management Plan. I also consent to the release of the information contained in this Diabetes Medical Management Plan to all staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety.

**Acknowledged and received by:**

\_\_\_\_\_  
 Parent/Guardian Date \_\_\_\_\_

**PART III TO BE COMPLETED BY PRINCIPAL OR REGISTERED NURSE**

**ACTION PLAN CHECK LIST FOR SCHOOL PERSONNEL**

- |   |     |    |     |  |              |     |    |       |
|---|-----|----|-----|--|--------------|-----|----|-------|
| • Diabetes Medical Management Plan pages 1-5 completed  | yes | no |     |  |              |     |    |       |
| • Quick Reference Emergency Plan Part A and B completed | yes | no |     |  |              |     |    |       |
| • Medication authorization complete                     | yes | no |     |  |              |     |    |       |
| • Medication maintained in school-designated area       | yes | no |     |  |              |     |    |       |
| • Expiration date of medication (s)                     |     |    |     |  |              |     |    | _____ |
| • Parental provided supplies maintained in school       | yes | no |     |  |              |     |    |       |
| • Staff trained in medication administration            | yes | no |     |  |              |     |    |       |
| • Staff trained in Diabetes education                   | yes | no |     |  |              |     |    |       |
| • Copies of plan provided to:                           |     |    |     |  |              |     |    |       |
| Educational   | yes | no | n/a |  | After school | yes | no | n/a   |
| Athletic  | yes | no | n/a |  | Food service | yes | no | n/a   |

Full Diabetes Action Plan has been implemented

\_\_\_\_\_  
 Principal or Registered Nurse Date \_\_\_\_\_  
 Source: U.S. Department of Health and Human Resources, National Diabetes Education Program. (June 2003). *Helping the Student with Diabetes Succeed: A Guide for School Personnel*. NIH Publication No. 03-5217,

**OFFICE OF CATHOLIC SCHOOLS DIOCESE OF ARLINGTON  
 QUICK REFERENCE EMERGENCY PLAN  
 Part A of Diabetes Medical Management Plan  
 HYPOGLYCEMIA  
 (Low Blood Sugar)**

See reverse for  
Part B and  
signatures

Student Name \_\_\_\_\_

School \_\_\_\_\_

Teacher/grade \_\_\_\_\_

Mother/Guardian \_\_\_\_\_

Father/Guardian \_\_\_\_\_

Home phone \_\_\_\_\_

Work phone \_\_\_\_\_

Cell \_\_\_\_\_

Home phone \_\_\_\_\_

Work phone \_\_\_\_\_

Cell \_\_\_\_\_

Trained Diabetes Personnel \_\_\_\_\_

Contact Number(s) \_\_\_\_\_

**NEVER SEND A CHILD WITH SUSPECTED LOW BLOOD SUGAR ANYWHERE ALONE.**

<p><b>Causes of Hypoglycemia</b></p> <ul style="list-style-type: none"> <li>• Too much insulin</li> <li>• Missed food</li> <li>• Delayed food</li> <li>• Too much or too intense exercise</li> <li>• Unscheduled exercise</li> </ul>	<p><b>Onset</b></p> <ul style="list-style-type: none"> <li>• Sudden</li> </ul>
--	--

**Symptoms**

**Mild**

- Hunger
- Shakiness
- Weakness
- Paleness
- Anxiety
- Irritability
- Dizziness

- Sweating
- Drowsiness
- Personality change
- Inability to concentrate

• Other: \_\_\_\_\_

Circle student's usual symptoms.

**Moderate**

- Headache
- Behavior change
- Poor coordination

- Blurry vision
- Weakness
- Slurred Speech
- Confusion

• Other \_\_\_\_\_

Circle student's usual symptoms.

**Severe**

- Loss of consciousness
- Seizure
- Inability to swallow

Circle student's usual symptoms.

**Actions needed**  
 Notify School Nurse or Trained Diabetes Personnel. If possible check blood sugar, per Diabetes Medical Management Plan. When in doubt, always TREAT FOR HYPOGLYCEMIA

**Mild**

- Student may/may not treat self.
- Provide quick-sugar source.  
 3-4 glucose tablets  
 or  
 4 oz. juice  
 or  
 6 oz. regular soda  
 or  
 3 teaspoons of glucose gel
- Wait 10 to 15 minutes.
- Recheck blood glucose.
- Repeat food if symptoms persist or blood glucose is less than \_\_\_\_\_.
- Follow with a snack of carbohydrate and protein (e.g., cheese and crackers).

**Moderate**

- Someone assists.
- Give student quick-sugar source per MILD guidelines.
- Wait 10 to 15 minutes.
- Recheck blood glucose.
- Repeat food if symptoms persist or blood glucose is less than \_\_\_\_\_.
- Follow with a snack of carbohydrate and protein (e.g., cheese and crackers).

**Severe**

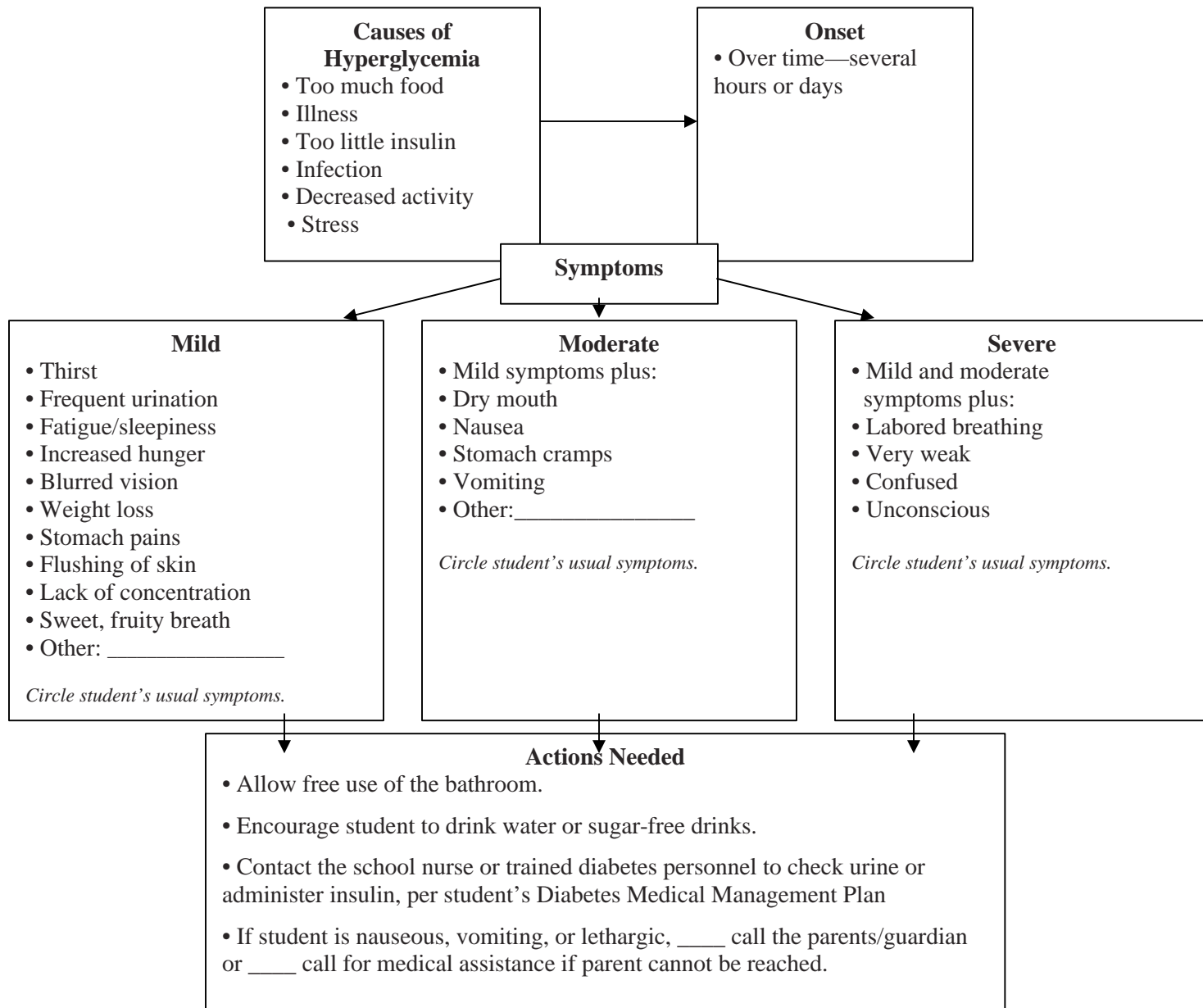
- Don't attempt to give anything by mouth.
- Position on side, if possible.
- Contact school nurse or trained diabetes personnel.
- Administer glucagon, as prescribed.
- Call 911.
- Contact parents/guardian.
- Stay with student.

**OFFICE OF CATHOLIC SCHOOLS DOCESE OF ARLINGTON**  
**QUICK REFERENCE EMERGENCY PLAN**  
**Part B of Diabetes Medical Management Plan**  
**HYPERGLYCEMIA**  
**(High Blood Sugar)**

\_\_\_\_\_  
 Student Name

\_\_\_\_\_  
 School

\_\_\_\_\_  
 Teacher/grade



***This quick reference emergency plan reflects orders stated in the Diabetes Medical Management plan and is authorized by;***

\_\_\_\_\_  
 Licensed Health Care Provider

\_\_\_\_\_  
 Telephone

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Parent

\_\_\_\_\_  
 Telephone

\_\_\_\_\_  
 Date

OFFICE OF CATHOLIC SCHOOLS DIOCESE OF ARLINGTON  
ALLERGY ACTION PLAN

PROCEDURE ON REVERSE

**PART I TO BE COMPLETED BY PARENT**

Student \_\_\_\_\_ D.O.B \_\_\_\_\_ School \_\_\_\_\_

ALLERGY \_\_\_\_\_ Teacher/Grade \_\_\_\_\_

**Emergency Contacts:**

Name/Relationship

Phone Number(s)

\_\_\_\_\_ 1.) \_\_\_\_\_ 2.) \_\_\_\_\_

\_\_\_\_\_ 1.) \_\_\_\_\_ 2.) \_\_\_\_\_

Asthmatic " Yes\* " No \*High risk for severe reaction

**PART II TO BE COMPLETED BY LICENSED HEALTH CARE PROVIDER**

**TREATMENT PLAN FOR ALLERGY**



For medications administered during school, complete required EpiPen/Medication Authorization forms.

**Symptoms:**

**Give Checked Medication:**

- |  |             |               |
|--|-------------|---------------|
| • If a food allergen has been ingested, but <i>no symptoms</i> :         | Epinephrine | Antihistamine |
| • Mouth Itching, tingling, or swelling of lips, tongue, mouth            | Epinephrine | Antihistamine |
| • Skin Hives, itchy rash, swelling of the face or extremities            | Epinephrine | Antihistamine |
| • Gut Nausea, abdominal cramps, vomiting, diarrhea                       | Epinephrine | Antihistamine |
| • Throat* Tightening of throat, hoarseness, hacking cough                | Epinephrine | Antihistamine |
| • Lung* Shortness of breath, repetitive coughing, wheezing               | Epinephrine | Antihistamine |
| • Heart* Thready pulse, low blood pressure, fainting, pale, blueness     | Epinephrine | Antihistamine |
| • Other* _____   | Epinephrine | Antihistamine |
| • If reaction is progressing (several of the above areas affected), give | Epinephrine | Antihistamine |

\*Potentially life-threatening. The severity of symptoms can quickly change.

**DOSAGE**

**Epinephrine:** inject intramuscularly (circle one) EpiPen® EpiPen® Jr.

**Antihistamine:** give \_\_\_\_\_ medication/dose/route

**Other:** give \_\_\_\_\_ medication/dose/route

**PLACE EMERGENCY CALLS**

1. Call 911. State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Dr. \_\_\_\_\_ at \_\_\_\_\_

\_\_\_\_\_  
Licensed Health Care Provider (Print) Licensed Health Care Provider (Signature) Telephone Date

I approve of this Allergy Action Plan, I give permission for school personnel to perform and carry out the tasks as outlined. I consent to the release of the information contained in this management plan to all staff members and others who have custodial care of my child and who may need to know this information to maintain my child's health and safety.

\_\_\_\_\_  
Parent / Guardian Signature Telephone Date

**OFFICE OF CATHOLIC SCHOOLS DIOCESE OF ARLINGTON**  
**ALLERGY ACTION PLAN**  
**PAGE 2**

**PART III TO BE COMPLETED BY PRINCIPAL OR REGISTERED NURSE**

Student \_\_\_\_\_ School \_\_\_\_\_ Teacher/Grade \_\_\_\_\_

Parent/Caregiver \_\_\_\_\_ Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

ALLERGY \_\_\_\_\_


**ACTION PLAN CHECK LIST FOR SCHOOL PERSONNEL**

- |   |     |    |       |
|---|-----|----|-------|
| • Allergy Action Plan Part I and II, complete     | yes | no |       |
| • Medication authorization complete               | yes | no | n/a   |
| • EpiPen authorization complete                   | yes | no | n/a   |
| • Medication maintained in school designated area | yes | no |       |
| • Medication self carried                         | yes | no |       |
| • Expiration date of medication(s)                |     |    | _____ |
|   |     |    | _____ |
| • Staff trained in medication administration      | yes | no |       |
| • Copies of plan provided to:                     |     |    |       |
| Educational                                       | yes | no | n/a   |
| Athletic  | yes | no | n/a   |
| After school                                      | yes | no | n/a   |
| Food service                                      | yes | no | n/a   |

**Trained staff**

Name	Date	Location
Name	Date	Location
Name	Date	Location
Name	Date	Location

The EpiPen is self-injecting. It is used in cases of anaphylaxis of any cause.



Directions for use:

- Remove gray safety cap and grasp EpiPen with your fist
- Press the black end of EpiPen against outer thigh until you hear a click and needle is released. EpiPen is designed to be used through clothing if necessary.
- **Maintain EpiPen in position for 10 seconds**
- Remove EpiPen, call 911 for immediate follow up and send the pen with the caregiver to the emergency room.
- Use care with exposed needle. Destroy needle by placing a penny into empty tube and inserting spent pen. New packaging allows inserting the pen without a penny.

**Full Allergy Action plan has been implemented.**

\_\_\_\_\_  
Principal or Registered Nurse

\_\_\_\_\_  
Date



**OFFICE OF CATHOLIC SCHOOLS DIOCESE OF ARLINGTON**  
**ASTHMA ACTION PLAN**  
**PAGE 2**

**PART III TO BE COMPLETED BY PRINCIPAL OR REGISTERED NURSE**

Student \_\_\_\_\_ School \_\_\_\_\_ Teacher/Grade \_\_\_\_\_

Parent/Caregiver \_\_\_\_\_ Phone (H) \_\_\_\_\_ Phone (W) \_\_\_\_\_ Phone (Cell) \_\_\_\_\_

Physician \_\_\_\_\_ Office phone number \_\_\_\_\_

**ASTHMA ACTION PLAN CHECK LIST FOR SCHOOL PERSONNEL**

- Asthma Action Plan Part I and II, complete yes      no
- Medication authorization complete yes      no      n/a
- Inhaler authorization complete yes      no      n/a
- Medication maintained in school designated area yes      no
- Medication self carried yes      no
- Expiration date of medication (s) \_\_\_\_\_
  
- Staff trained in medication administration yes      no
- Copies of plan provided to:
 

Educational	yes	no	n/a	After school	yes	no	n/a
Athletic	yes	no	n/a	Food service	yes	no	n/a

**IMMEDIATE ACTION FOR SYMPTOMS**

<b>IF YOU SEE THIS:</b>	<b>DO THIS:</b>
Complains of chest tightness Coughing Difficulty breathing Wheezing	1. Stop activity 2. Give one puff of rescue inhaler 3. Wait at least 1 minute 4. Give second puff of rescue inhaler 5. Allow student to rest 6. If no improvement in 15 minutes, repeat steps 2-4 7. If symptoms worsen call 911 and parents/emergency contact
<b>IF YOU SEE THIS</b>	<b>DO THIS IMMEDIATELY</b>
Coughs constantly Struggles or gasps for breath Chest and neck pull in with breathing Stooped over posture Trouble walking or talking Lips or fingernails are gray or blue	1. Call 911 2. Give rescue medication 3. Call parents/emergency contact

**Full Asthma Action Plan has been implemented.**

\_\_\_\_\_  
Principal or Registered Nurse

\_\_\_\_\_  
Date

**OFFICE OF CATHOLIC SCHOOLS DIOCESE OF ARLINGTON  
CONFIDENTIAL STUDENT HEALTH HISTORY UPDATE**

**PARENT/GUARDIAN:** Please complete this form at the beginning of each school year.

Name \_\_\_\_\_ Sex: M F DOB: \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_

Mother / Guardian \_\_\_\_\_ Work # \_\_\_\_\_ Home # \_\_\_\_\_ Cell # \_\_\_\_\_

Father / Guardian \_\_\_\_\_ Work # \_\_\_\_\_ Home # \_\_\_\_\_ Cell# \_\_\_\_\_

Physician \_\_\_\_\_ Phone# \_\_\_\_\_ School Year \_\_\_\_\_

**Complete the following checklist by indicating any of the following student conditions, past or present.**

	YES*	NO	DATE
Allergies / Environmental			
Allergies / Food			
Allergies / Insect Stings or Bees			
Allergies / Latex			
Allergies / Medications			
Allergies / Other			
Asthma / Breathing Problem			
Behavioral Problem			
Bladder / Kidney Disorder			
Bleeding / Clotting Disorder			
Bone / Joint/Muscular Disorder			
Cancer			
Convulsions / Epilepsy / Seizure			
Dental Problem			
Developmental Problem			
Dizziness or Fainting			
Diabetes			
Dietary Restriction			
Digestive / Bowel Problem			
Eating Disorder			
Endocrine Disorder			
Head or Spinal Injury			
Headaches / Migraines			

	YES*	NO	DATE
Hearing Problem			
Heart Defect or Disease			
Joint or Ligament Problem			
Learning Disability			
Menstrual Disorder			
Neurological Disorder			
Obesity			
Orthopedic Problem			
Seizure			
Stomach Problem			
Teething			
Tuberculosis			
Unconscious			
Wheezing			
Other: (explain below)			

**SAMPLE**

\*Provide details for all items above marked **YES** : \_\_\_\_\_

Does the student's health condition require medically necessary medications or specialized health care treatments in school? YES NO Explain \_\_\_\_\_

Does the student take any medications, homeopathic supplements, or nutritional & performance supplements? YES NO Explain. \_\_\_\_\_

Specifically **during or after exercise**, has the student experienced any of the following? Check all that apply:

- Fainting / Passing-Out
- Heat Stroke
- Severe Lightheadedness / Dizziness
- Coughing / Wheezing
- Excessive Bruising
- Extreme Shortness of Breath
- Chest Pain
- Numbness / Tingling in \_\_\_\_\_
- NONE APPLY

Was a Medical Evaluation done as a result of any of the above symptoms during exercise? YES NO Outcome: \_\_\_\_\_

• **YES** • **NO** **CONSENT FOR TREATMENT:** I give my permission for qualified school personnel to provide routine health care and first aid to my child as may be necessary during school and after school activities. I assume full responsibility for providing the school with all necessary student over-the-counter or prescription medications as well as necessary medical treatment supplies and authorizations.

• **YES** • **NO** **CONSENT TO SHARE INFORMATION:** The school nurse and/or health aide have my permission to share my child's confidential health information, on a need to know basis, with appropriate members of the educational staff, primary healthcare providers and extended day, for use in meeting the educational and health needs of my student. This consent includes the sharing of personally identifiable health record information during immunization and communicable disease surveillance audits by the Virginia Department of Health, and the Virginia Department of Social Services for licensed program compliance, if applicable.

Parent / Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**OFFICE OF CATHOLIC SCHOOLS DIOCESE OF ARLINGTON  
EPIPEN AUTHORIZATION**

Release and indemnification agreement

**PLEASE READ INFORMATION AND PROCEDURES ON REVERSE SIDE**

**PART I TO BE COMPLETED BY PARENT OR GUARDIAN**

I hereby request designated school personnel to administer an epinephrine injection as directed by this authorization. I agree to release, indemnify, and hold harmless the designated school personnel, or agents from lawsuits, claim expense, demand or action, etc., against them for administering this injection, provided the designated school personnel comply with the Licensed Healthcare Provider (LHCP) or parent or guardian orders set forth in accordance with the provision of part II below. I am aware that the injection may be administered by a specifically trained non-health professional. I have read the procedures outlined on the back of this form and assume responsibility as required

**I understand that emergency medical services (EMS) will always be called when epinephrine is given, whether or not the student manifests any symptoms of anaphylaxis.**

Student Name (Last, First, Middle)		Date of Birth	
Allergies	School	School Year	
No LPN or clinic room aide shall administer inhaler or treatment, unless the principal has reviewed all the required clearances			
_____	_____	_____	_____
Parent or Guardian Signature	Daytime Telephone	Date	

**PART II TO BE COMPLETED BY LICENSED HEALTH CARE PROVIDER WITH NO ABBREVIATIONS.**

Emergency injections may be administered by non-health professionals. These persons shall be trained by qualified registered nurses to administer the injection. For this reason, only pre-measured doses of epinephrine (EpiPen) and injector shall be given. It should be noted that these staff members are not trained observers. They cannot observe for the development of symptoms before administering the injection.



The following injection will be given immediately after reported exposure to \_\_\_\_\_ (Indicate specific allergens)

Route of Exposure: ? Ingestion ? Skin contact ? Inhalation ? Insect bite or sting

Check  appropriate boxes:

- ? EpiPen
  - ? Give the pre-measured dose of 0.3 mg epinephrine 1:1000 aqueous solution (0.3cc) by auto injection intramuscularly in anterolateral thigh.
  - ? Repeat the dose in 15 minutes if EMS has not arrived. (Two pre-measured doses will be needed in school.)
- ? EpiPen Jr.
  - ? Give the pre-measured dose of 0.15 mg epinephrine 1:2000 aqueous solution (0.3 cc) by auto injection, intramuscularly in anterolateral thigh.
  - ? Repeat the dose in 15 minutes if EMS has not arrived. (Two pre-measured doses will be needed in school.)

**COMMON SIDE EFFECTS**

EFFECTIVE DATE: Start: _____ End: _____	If the student is taking more than one medication at school, list sequence in which medications are to be taken
--	---

Check  appropriate box:

- ? I believe that this student has received adequate information on how and when to use an EpiPen, and has demonstrated its proper use.
  - a. The student is to carry an EpiPen during school hours with principal approval. The student can use the EpiPen properly in an emergency.
  - b. One additional dose, to be used as backup, should be kept in clinic or other school location.
- ? The EpiPen will be kept in the school clinic or other school approved location \_\_\_\_\_.

Allergy Action Plan is attached.

_____ Licensed Health Care Provider (Print or Type)	_____ Licensed Health Care Provider (Signature)	_____ Telephone or Fax	_____ Date
_____ Parent or Guardian (Print or Type)	_____ Parent or Guardian Signature	_____ Telephone	_____ Date
_____ Student Signature (Required if student carries EpiPen)			_____ Date

**PART III TO BE COMPLETED BY PRINCIPAL OR REGISTERED NURSE**

Check  as appropriate:

- ? Parts I and II above are completed including signatures. (It is acceptable if all items in part II are written on the LHCP stationery or a prescription pad.)
- ? EpiPen is appropriately labeled. \_\_\_\_\_ Date by which any unused EpiPens are to be collected by the parent (within one week after expiration of the physician order or on the last day of school).
- ? I have reviewed the proper use of an EpiPen with the student and agree/disagree that student should self carry in school.

_____ Signature	_____ Date
--------------------	---------------

## PARENT INFORMATION ABOUT MEDICATION PROCEDURES

1. **In no case may any health, school, or staff member administer any medication outside the framework of the procedures outlined here in the *Office of Catholic Schools Policies and Guidelines* and *Virginia School Health Guidelines* manual.**
2. **Schools do NOT provide medications for student use.**
3. Medications should be taken at home whenever possible. The first dose of any new medication must be given at home to ensure the student does not have a negative reaction.
4. Medication forms are required for each Prescription and Over The Counter (OTC) medication administered in school.
5. **All medication taken in school must have a parent/guardian signed authorization. Prescription medications, herbals and OTC medications taken for 4 or more consecutive days **also** require a licensed healthcare provider's (LHCP) written order. **No medication will be accepted by school personnel without the accompanying complete and appropriate medication authorization form.****
6. **The parent or guardian must transport medications to and from school.**
7. Medication must be kept in the school health office, or other principal approved location, during the school day. All medication will be stored in a locked cabinet or refrigerator, within a locked area, accessible only to authorized personnel, unless the student has prior written approval to self-carry a medication (inhaler, Epi-pen). If the student self carries, it is advised that a backup medication be kept in the clinic.
8. Parents/guardians are responsible for submitting a new medication authorization form to the school at the start of the school year and each time there is a change in the dosage or the time of medication administration.
9. A Licensed Health Care Provider (LHCP) may use office stationery, prescription pad or other appropriate documentation in lieu of completing Part II. The following information written in lay language with no abbreviations must be included and attached to this medication administration form. Signed faxes are acceptable.
  - a. Student name
  - b. Date of Birth
  - c. Diagnosis
  - d. Signs or symptoms
  - e. Name of medication to be given in school
  - f. Exact dosage to be taken in school
  - g. Route of medication
  - h. Time and frequency to give medications, as well as exact time interval for additional dosages.
  - i. Sequence in which two or more medications are to be administered
  - j. Common side effects
  - k. Duration of medication order or effective start and end dates
  - l. LHCP's name, signature and telephone number
  - m. Date of order
10. All prescription medications, including physician's samples, must be in their original containers and labeled by a LHCP or pharmacist. Medication must not exceed its expiration date.
11. All Over the Counter (OTC) medication must be in the original, small, sealed container with the name of the medication and it's expiration date clearly visible. Parents/guardians must label the original container of the OTC with:
  - a. Name of student
  - b. Exact dosage to be taken in school
  - c. Frequency or time interval dosage is to be administered
12. The student is to come to the clinic or a predetermined location at the prescribed time to receive medication. Parents must develop a plan with the student to ensure compliance. Medication will be given no more than one half hour before or after the prescribed time.
13. **Students are NOT permitted to self medicate. The school does not assume responsibility for medication taken independently by the student.** Exceptions may be made on a case-by-case basis for students who demonstrate the capability to self-administer emergency life saving medications (e.g. inhaler, Epi-pen)
14. Within one week after expiration of the effective date on the order, or on the last day of school, the parent or guardian must personally collect any unused portion of the medication. Medications not claimed within that period will be destroyed.

OFFICE OF CATHOLIC SCHOOLS DIOCESE OF ARLINGTON

INHALER AUTHORIZATION

Release and indemnification agreement

PLEASE READ INFORMATION AND PROCEDURES ON REVERSE SIDE

PART I TO BE COMPLETED BY PARENT

I hereby request designated school personnel to administer an inhaler as directed by this authorization. I agree to release, indemnify, and hold harmless the designated school personnel, or agents from lawsuits, claim expense, demand or action, etc., against them for helping this student use an inhaler, provided the designated school personnel comply with the Licensed Healthcare Provider (LHCP) or parent or guardian orders set forth in accordance with the provision of part II below. I have read the procedures outlined on the back of this form and assume responsibility as required

Inhaler ? Renewal ? New (If new, the first full dose must be given at home to assure that the student does not have a negative reaction.)

First dose was given: Date \_\_\_\_\_ Time \_\_\_\_\_

Student Name (Last, First, Middle)

Date of Birth

Allergies

School

School Year

No LPN or clinic room aide shall administer inhaler or treatment unless the principal has reviewed all the required clearances.

Parent or Guardian Signature

Telephone

Date



PART II TO BE COMPLETED BY LICENSED HEALTH CARE PROVIDER (LAY LANGUAGE, NO ABBREVIATIONS)

DIAGNOSIS:

LIST TRIGGERS:

SIGNS / SYMPTOMS

MEDICATION AND ROUTE:

DOSAGE TO BE GIVEN AT SCHOOL

INTERVAL FOR REPEATING DOSAGE:

TIME TO BE GIVEN:

COMMON SIDE EFFECTS:

EFFECTIVE DATE:

Start: End:

If the student is taking more than one medication at school, list sequence in which inhalers are to be taken

Check ✓ the appropriate boxes:

I believe that this student has received information on how and when to use an inhaler and that he or she demonstrates its proper use.

The student is to carry an inhaler during school and during sanctioned events with principal approval. (An additional inhaler, to be used as backup, WILL BE kept in the clinic or other approved school location.)

It is not necessary for the student to carry his inhaler during school, the inhaler will be kept in the clinic or other approved school location.

Asthma Action Plan is attached

Licensed Health Care Provider (Print)

Licensed Health Care Provider (Signature)

Telephone or Fax

Date

Parent or Guardian

Parent or Guardian Signature

Telephone

Date

Student Signature (Required if student carries inhaler)

Date

PART III TO BE COMPLETED BY PRINCIPAL OR REGISTERED NURSE

Check ✓ as appropriate:

? Parts I and II above are completed including signatures. (It is acceptable if all items in part II are written on the LHCP stationery or a prescription pad.)

? Inhaler is appropriately labeled. \_\_\_\_\_ Date by which any unused inhaler is to be collected by the parent (within one week after expiration of the physician order or on the last day of school).

? I have reviewed the proper use of the inhaler with the student and agree/disagree that student should self carry in school.

Signature

Date

## PARENT INFORMATION ABOUT MEDICATION PROCEDURES

1. **In no case may any health, school, or staff member administer any medication outside the framework of the procedures outlined here in the *Office of Catholic Schools Policies and Guidelines* and *Virginia School Health Guidelines* manual.**
2. **Schools do NOT provide medications for student use.**
3. Medications should be taken at home whenever possible. The first dose of any new medication must be given at home to ensure the student does not have a negative reaction.
4. Medication forms are required for each Prescription and Over The Counter (OTC) medication administered in school.
5. **All medication taken in school must have a parent/guardian signed authorization. Prescription medications, herbals and OTC medications taken for 4 or more consecutive days also require a licensed healthcare provider's (LHCP) written order. No medication will be accepted by school personnel without the accompanying complete and appropriate medication authorization form.**
6. **The parent or guardian must transport medications to and from school.**
7. Medication must be kept in the school health office, or other principal approved location, during the school day. All medication will be stored in a locked cabinet or refrigerator, within a locked area, accessible only to authorized personnel, unless the student has prior written approval to self-carry a medication (inhaler, Epi-pen). If the student self carries, it is advised that a backup medication be kept in the clinic.
8. Parents/guardians are responsible for submitting a new medication authorization form to the school at the start of the school year and each time there is a change in the dosage or the time of medication administration.
9. A Licensed Health Care Provider (LHCP) may use office stationery, prescription pad or other appropriate documentation in lieu of completing Part II. The following information written in lay language with no abbreviations must be included and attached to this medication administration form. Signed faxes are acceptable.
  - a. Student name
  - b. Date of Birth
  - c. Diagnosis
  - d. Signs or symptoms
  - e. Name of medication to be given in school
  - f. Exact dosage to be taken in school
  - g. Route of medication
  - h. Time and frequency to give medications, as well as exact time interval for additional dosages.
  - i. Sequence in which two or more medications are to be administered
  - j. Common side effects
  - k. Duration of medication order or effective start and end dates
  - l. LHCP's name, signature and telephone number
  - m. Date of order
10. All prescription medications, including physician's samples, must be in their original containers and labeled by a LHCP or pharmacist. Medication must not exceed its expiration date.
11. All Over the Counter (OTC) medication must be in the original, small, sealed container with the name of the medication and its expiration date clearly visible. Parents/guardians must label the original container of the OTC with:
  - a. Name of student
  - b. Exact dosage to be taken in school
  - c. Frequency or time interval dosage is to be administered
12. The student is to come to the clinic or a predetermined location at the prescribed time to receive medication. Parents must develop a plan with the student to ensure compliance. Medication will be given no more than one half hour before or after the prescribed time.
13. **Students are NOT permitted to self medicate. The school does not assume responsibility for medication taken independently by the student.** Exceptions may be made on a case-by-case basis for students who demonstrate the capability to self-administer emergency life saving medications (e.g. inhaler, Epi-pen)
14. Within one week after expiration of the effective date on the order, or on the last day of school, the parent or guardian must personally collect any unused portion of the medication. Medications not claimed within that period will be destroyed.

**OFFICE OF CATHOLIC SCHOOLS DIOCESE OF ARLINGTON**  
**MEDICATION AUTHORIZATION**  
**NOT FOR EPI PEN OR INHALER AUTHORIZATION**  
 Release and indemnification agreement

**PLEASE READ INFORMATION AND PROCEDURES ON REVERSE SIDE**

**PART I TO BE COMPLETED BY PARENT OR GUARDIAN**

I hereby request designated school personnel to administer medication as directed by this authorization. I agree to release, indemnify, and hold harmless the designated school personnel, or agents from lawsuits, claim expense, demand or action, etc., against them for helping this student use medication, provided the designated school personnel comply with the Licensed Healthcare Provider (LHCP) or parent or guardian orders set forth in accordance with the provision of part II below. I have read the procedures outlined on the back of this form and assume responsibility as required

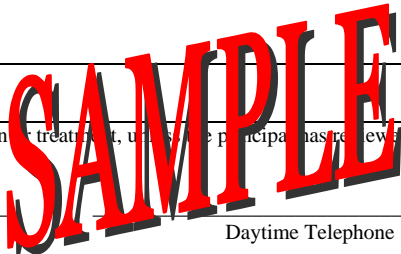
Medication \_\_\_\_\_ ? Renewal \_\_\_\_\_ ? New (If new, the first full dose must be given at home to assure that the student does not have a negative reaction.)  
 First dose was given: Date \_\_\_\_\_ Time \_\_\_\_\_

Student Name (Last, First, Middle) \_\_\_\_\_ Date of Birth \_\_\_\_\_

Allergies \_\_\_\_\_ School \_\_\_\_\_ School Year \_\_\_\_\_

No LPN or clinic room aide shall administer medication or treatment, unless the principal has renewed all the required clearances.

\_\_\_\_\_  
 Parent or Guardian Signature Daytime Telephone \_\_\_\_\_ Date \_\_\_\_\_



**PART II TO BE COMPLETED BY PARENT OR GUARDIAN FOR OCCASIONAL OVER THE COUNTER (OTC) MEDICATION. LICENSED HEALTH CARE PROVIDER (LHCP) MUST COMPLETE AND SIGN FOR ALL OTHER MEDICATIONS AND OTC'S ADMINISTERED FOR 4 OR MORE DAYS.**

The school discourages the use of medication by students in school during the school day. Any necessary medication that possibly can be taken before or after school should be so prescribed. Injectable medications are not administered in schools except in specific situations with appropriate forms that comply with LHCP orders and are signed by parent or guardian. School personnel will, when it is absolutely necessary, administer medication during the school day and while participating in outdoor education programs and school crisis situations according to the procedures outlined on the back of the form. Information should be written in lay language with no abbreviations.

DIAGNOSIS: \_\_\_\_\_ SIGNS / SYMPTOMS: \_\_\_\_\_

MEDICATION: \_\_\_\_\_ ROUTE: \_\_\_\_\_

DOSAGE TO BE GIVEN AT SCHOOL: \_\_\_\_\_ TIMES OR INTERVAL TO BE GIVEN: \_\_\_\_\_

EFFECTIVE DATE: Start: \_\_\_\_\_ End: \_\_\_\_\_ If the student is taking more than one medication at school, list sequence in which medications are to be taken

COMMON SIDE EFFECTS: \_\_\_\_\_

\_\_\_\_\_  
 Licensed Health Care Provider (Print or Type) Licensed Health Care Provider (Signature) Telephone or Fax \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_  
 Parent or Guardian Name (Print or Type) Parent or Guardian (Signature) Telephone \_\_\_\_\_ Date \_\_\_\_\_

**PART III TO BE COMPLETED BY PRINCIPAL OR REGISTERED NURSE**

Check  as appropriate:  
 ? Parts I and II above are completed including signatures. (It is acceptable if all items in part II are written on the LHCP stationery or a prescription pad.)

? Medication is appropriately labeled. \_\_\_\_\_ Date by which any unused medication is to be collected by the parent (Within one week after expiration of the physician order or on the last day of school).

\_\_\_\_\_  
 Signature Date \_\_\_\_\_

## PARENT INFORMATION ABOUT MEDICATION PROCEDURES

1. **In no case may any health, school, or staff member administer any medication outside the framework of the procedures outlined here in the *Office of Catholic Schools Policies and Guidelines* and *Virginia School Health Guidelines* manual.**
2. **Schools do NOT provide medications for student use.**
3. Medications should be taken at home whenever possible. The first dose of any new medication must be given at home to ensure the student does not have a negative reaction.
4. Medication forms are required for each Prescription and Over The Counter (OTC) medication administered in school.
5. **All medication taken in school must have a parent/guardian signed authorization. Prescription medications, herbals and OTC medications taken for 4 or more consecutive days also require a licensed healthcare provider's (LHCP) written order. No medication will be accepted by school personnel without the accompanying complete and appropriate medication authorization form.**
6. **The parent or guardian must transport medications to and from school.**
7. Medication must be kept in the school health office, or other principal approved location, during the school day. All medication will be stored in a locked cabinet or refrigerator, within a locked area, accessible only to authorized personnel, unless the student has prior written approval to self-carry a medication (inhaler, Epi-pen). If the student self carries, it is advised that a backup medication be kept in the clinic.
8. Parents/guardians are responsible for submitting a new medication authorization form to the school at the start of the school year and each time there is a change in the dosage or the time of medication administration.
9. A Licensed Health Care Provider (LHCP) may use office stationery, prescription pad or other appropriate documentation in lieu of completing Part II. The following information written in lay language with no abbreviations must be included and attached to this medication administration form. Signed faxes are acceptable.
  - a. Student name
  - b. Date of Birth
  - c. Diagnosis
  - d. Signs or symptoms
  - e. Name of medication to be given in school
  - f. Exact dosage to be taken in school
  - g. Route of medication
  - h. Time and frequency to give medications, as well as exact time interval for additional dosages.
  - i. Sequence in which two or more medications are to be administered
  - j. Common side effects
  - k. Duration of medication order or effective start and end dates
  - l. LHCP's name, signature and telephone number
  - m. Date of order
10. All prescription medications, including physician's samples, must be in their original containers and labeled by a LHCP or pharmacist. Medication must not exceed its expiration date.
11. All Over the Counter (OTC) medication must be in the original, small, sealed container with the name of the medication and its expiration date clearly visible. Parents/guardians must label the original container of the OTC with:
  - a. Name of student
  - b. Exact dosage to be taken in school
  - c. Frequency or time interval dosage is to be administered
12. The student is to come to the clinic or a predetermined location at the prescribed time to receive medication. Parents must develop a plan with the student to ensure compliance. Medication will be given no more than one half hour before or after the prescribed time.
13. **Students are NOT permitted to self medicate. The school does not assume responsibility for medication taken independently by the student.** Exceptions may be made on a case-by-case basis for students who demonstrate the capability to self-administer emergency life saving medications (e.g. inhaler, Epi-pen)
14. Within one week after expiration of the effective date on the order, or on the last day of school, the parent or guardian must personally collect any unused portion of the medication. Medications not claimed within that period will be destroyed.

**ELEMENTARY/MIDDLE SCHOOL HANDBOOK AGREEMENT FORM**

**PARENT/GUARDIAN**

I have received a current copy of the Parent/Student Handbook. In doing so, I have explained the content of this document to my child(ren). I acknowledge and agree to the policies contained therein, and will require my child(ren) to comply with the policies which apply to students.

I also realize during my child's enrollment at the school I will be informed from time to time, formally or informally, of various changes in school and/or Diocesan policies. I understand the school and/or the Diocese reserves the right to change policies at any time with or without advance notice. I further understand it is required for me to sign this form in order to continue my child's enrollment at the school.

**SAMPLE**

\_\_\_\_\_  
(Parent Signature)

\_\_\_\_\_  
(Printed Name)

\_\_\_\_\_  
(Date)

**FOR MIDDLE SCHOOL STUDENTS ONLY**

**I have read the Parent/Student Handbook and agree to observe all school regulations.**

\_\_\_\_\_  
(Student Signature)

\_\_\_\_\_  
(Printed Name)

\_\_\_\_\_  
(Date)

PARENT PERMISSION FORM FOR SCHOOL-SPONSORED TRIP PARTICIPATION

Dear Parent or Legal Guardian:

Your son/daughter is eligible to participate in a school-sponsored activity requiring transportation to a location away from the school building. This activity will take place under the guidance and supervision of employees from \_\_\_\_\_ School. A brief description of the activity follows:

Curriculum Goal: \_\_\_\_\_

Destination: \_\_\_\_\_

Designated Supervisor of Activity: \_\_\_\_\_

Date and Time of Departure: \_\_\_\_\_

Date and Anticipated Time of Return: \_\_\_\_\_

Method of Transportation: \_\_\_\_\_ Student Cost: \_\_\_\_\_

**SAMPLE**

If you would like your child to participate in this event, please complete, sign, and return the following statement of consent. As parent or legal guardian, you remain fully responsible for any legal responsibility which may result from any personal actions taken by the named student. Please be advised that parents retain the right to "opt out of any field trip planned for their children. It should also be understood, in light of world conditions and specifically, threats of terrorism to Americans, it may be necessary to cancel any school-sponsored trip due to world and national developments. If further restrictions are imposed, the school/Diocese will not be responsible for the loss of any monies advanced for these planned trips.

1. Is your child required to take any medication during the field trip? \_\_\_\_\_ (Y or N)
2. If so, what medication? \_\_\_\_\_
3. Do you request the designated supervisor of activity to administer the medication stated above on this field trip? \_\_\_\_\_ (Y or N)
4. Do you wish your child to take his/her inhaler \_\_\_ or Epi-pen \_\_\_ or Glucagon Emergency Kit ) \_\_\_ on the trip?

I hereby request that my child, \_\_\_\_\_, be allowed to participate in the event described above. I understand that this event will take place away from the school grounds and that my child will be under the supervision of the designated school employee on the stated dates. I further consent to the conditions stated above on participation in this event, including the method of transportation. If I cannot be contacted in an emergency, the school has my permission to take my child to the emergency room of the nearest hospital and I hereby authorize its medical staff to provide treatment which a physician deems necessary for the well-being of my child. I understand it may be necessary to cancel any school-sponsored trip due to world and national developments and the school/Diocese will not be responsible for the loss of any monies advanced for these planned trips.

Parent's Name (Please Print) \_\_\_\_\_

Home Phone # \_\_\_\_\_

Work Phone # \_\_\_\_\_

Parent's Signature \_\_\_\_\_

I accept responsibility for my behavior:

Signature of Student \_\_\_\_\_

Emergency Contact Person (Please Print) \_\_\_\_\_ Emergency Ph # \_\_\_\_\_

Student's Current Medical Problem \_\_\_\_\_

Name of Physician \_\_\_\_\_ Phone Number \_\_\_\_\_

Insurance Company \_\_\_\_\_ ID # \_\_\_\_\_

Allergy to Medications \_\_\_\_\_

Allergies \_\_\_\_\_

Chaperones should take a copy of this form on the school-sponsored trip.

Please print clearly.

DIOCESE OF ARLINGTON PERMISSION FOR EMERGENCY CARE

To be completed by parent/guardian at beginning of school year

NAME OF STUDENT \_\_\_\_\_ Grade \_\_\_\_\_ Room # \_\_\_\_\_  
(nickname)

Address \_\_\_\_\_  
(Street) (City) (Zip)

Student's Date of Birth \_\_\_\_\_ ? Male ? Female Home Phone \_\_\_\_\_

Father's Name \_\_\_\_\_ Work Phone \_\_\_\_\_ Hours \_\_\_\_\_

Father's Email Address \_\_\_\_\_ Cell/Pager \_\_\_\_\_

Mother's Name \_\_\_\_\_ Work Phone \_\_\_\_\_ Hours \_\_\_\_\_

Mother's Email Address \_\_\_\_\_ Cell/Pager \_\_\_\_\_

Father's Address (if different) \_\_\_\_\_

Mother's Address (if different) \_\_\_\_\_

Father's Workplace & Address \_\_\_\_\_

Mother's Workplace & Address \_\_\_\_\_

Name(s) of Person(s) or Agency Having Legal Custody\* \_\_\_\_\_

Address \_\_\_\_\_

Persons NOT Authorized to pick up child from school\*

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Child's Doctor \_\_\_\_\_ Phone Number \_\_\_\_\_

Outstanding Medical History (e.g. diabetes, heart disease, contact lenses, hearing aids, etc.)

Child's Allergies (if any) \_\_\_\_\_ Action to Take \_\_\_\_\_

Medications Child is Taking \_\_\_\_\_ Date of Last Tetanus Shot \_\_\_\_\_

Insurance Company \_\_\_\_\_ Policy Number \_\_\_\_\_

**Emergency Contacts:** In the event a parent cannot be reached, **you must** give the name, address, and phone number of two persons who could pick up and take your child home in a timely manner.

1) \_\_\_\_\_  
(Name) (Address) (Relationship) (Phone)

2) \_\_\_\_\_  
(Name) (Address) (Relationship) (Phone)

I agree to notify the school within 24 hours if my child or any member of my immediate household has developed a communicable disease. I agree to notify the school immediately if the disease is life threatening.

I agree to pick up my sick or injured child in a timely manner when contacted. If I cannot be reached, the above emergency contacts can be called to pick up my child. Additionally, if I cannot be contacted in an emergency, the school has my permission to take my child to the emergency room of the nearest hospital and I hereby authorize its medical staff to provide treatment, which a physician deems necessary for the well-being of my child.

\_\_\_\_\_  
(Signature of Parent/Guardian)

\_\_\_\_\_  
(Date)

**COMMONWEALTH OF VIRGINIA  
SCHOOL ENTRANCE HEALTH FORM  
Health Information Form/Comprehensive Physical Examination Report/Certification of Immunization**

**Part I – HEALTH INFORMATION FORM**

State law (Ref. Code of Virginia § 22.1-270) requires that your child is immunized and receives a comprehensive physical examination before entering public kindergarten or elementary school. **The parent or guardian completes this page (Part I) of the form.** The Medical Provider completes Part II and Part III of the form. This form must be completed no longer than one year before your child's entry into school.

Name of School: \_\_\_\_\_ Current Grade: \_\_\_\_\_  
 Student's Name: \_\_\_\_\_  
 Student's Date of Birth: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Last First Middle  
 Sex: \_\_\_\_\_ State or Country of Birth: \_\_\_\_\_ Main Language Spoken: \_\_\_\_\_  
 Student's Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Name of Mother or Legal Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Work or Cell: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Name of Father or Legal Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Work or Cell: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Work or Cell: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Condition	Yes	Comments	Condition	Yes	Comments
Allergies (food, insects, drugs, latex)			Diabetes		
Allergies (seasonal)			Head or spinal injury		
Asthma or breathing problems			Hearing problems or deafness		
Attention-Deficit/Hyperactivity Disorder			Heart problems		
Behavioral problems			Hospitalizations		
Developmental problems			Lead poisoning		
Bladder problem			Muscle problems		
Bleeding problem			Seizures		
Bowel problem			Sickle Cell Disease (not trait)		
Cerebral Palsy			Speech problems		
Cystic fibrosis			Surgery		
Dental problems			Vision problems		

Describe any other important health-related information about your child (for example, feeding tube, oxygen support, hearing aid, etc.):

\_\_\_\_\_

\_\_\_\_\_

List all prescription, over-the-counter, and herbal medications your child takes regularly:

\_\_\_\_\_

\_\_\_\_\_

Check here if you want to discuss confidential information with the school nurse or other school authority.  Yes  No

Please provide the following information:

	Name	Phone	Date of Last Appointment
Pediatrician/primary care provider			
Specialist			
Dentist			
Case Worker (if applicable)			

Child's Health Insurance:  None  FAMIS Plus (Medicaid)  FAMIS  Private/Commercial/Employer sponsored

**I, \_\_\_\_\_ (do \_\_\_) (do not \_\_\_) authorize my child's health care provider and designated provider of health care in the school setting to discuss my child's health concerns and/or exchange information pertaining to this form. This authorization will be in place until or unless you withdraw it. You may withdraw your authorization at any time by contacting your child's school. When information is released from your child's record, documentation of the disclosure is maintained in your child's health or scholastic record.**

Signature of Parent or Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Signature of person completing this form: \_\_\_\_\_ Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Signature of Interpreter: \_\_\_\_\_ Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_





**Part III -- COMPREHENSIVE PHYSICAL EXAMINATION REPORT**

A qualified licensed physician, nurse practitioner, or physician assistant must complete Part III. The exam must be done no longer than one year before entry into kindergarten or elementary school (Ref. Code of Virginia § 22.1-270). Instructions for completing this form can be found at [www.vahealth.org/schoolhealth](http://www.vahealth.org/schoolhealth)

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex:  M  F

<b>Health Assessment</b>	<b>Date of Assessment:</b> ____/____/____ Weight: _____ lbs. Height: _____ ft. ____ in. Body Mass Index (BMI): _____ BP _____ <input type="checkbox"/> Age / gender appropriate history completed <input type="checkbox"/> Anticipatory guidance provided <b>TB Risk Assessment:</b> <input type="checkbox"/> No Risk <input type="checkbox"/> Positive/Referred Mantoux results: _____ mm	<b>Physical Examination</b> 1 = Within normal    2 = Abnormal finding    3 = Referred for evaluation or treatment <table style="width:100%; border:none;"> <tr> <td></td> <td style="text-align:center;">1</td> <td style="text-align:center;">2</td> <td style="text-align:center;">3</td> <td></td> <td style="text-align:center;">1</td> <td style="text-align:center;">2</td> <td style="text-align:center;">3</td> <td></td> <td style="text-align:center;">1</td> <td style="text-align:center;">2</td> <td style="text-align:center;">3</td> </tr> <tr> <td>HEENT</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td>Neurological</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td>Skin</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> </tr> <tr> <td>Lungs</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td>Abdomen</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td>Genital</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> </tr> <tr> <td>Heart</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td>Extremities</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td>Urinary</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> </tr> </table>		1	2	3		1	2	3		1	2	3	HEENT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurological	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lungs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Extremities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Urinary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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<b>EPSDT Screens <u>Required</u> for Head Start – include specific results and date:</b> Blood Lead: _____ Hct/Hgb _____																																																		

Developmental Screen	Assessed for:	Assessment Method:	Within normal	Concern identified:	Referred for Evaluation
	Emotional/Social				
	Problem Solving				
	Language/Communication				
	Fine Motor Skills				
	Gross Motor Skills				

<b>Hearing Screen</b>	<input type="checkbox"/> Screened at 20dB: Indicate Pass (P) or Refer (R) in each box.				<input type="checkbox"/> Referred to Audiologist/ENT <input type="checkbox"/> <b>Unable to test – needs rescreen</b> <input type="checkbox"/> Permanent Hearing Loss Previously identified: ___Left ___Right <input type="checkbox"/> Hearing aid or other assistive device
		1000	2000	4000	
	R				
	L				
<input type="checkbox"/> Screened by OAE (Otoacoustic Emissions): <input type="checkbox"/> Pass <input type="checkbox"/> Refer					

<b>Vision Screen</b>	<input type="checkbox"/> With Corrective Lenses (check if yes)				
		Stereopsis	<input type="checkbox"/> Pass <input type="checkbox"/> Fail	<input type="checkbox"/> Not tested	
	Distance	Both	R	L	Test used:
		20/	20/	20/	
<input type="checkbox"/> Pass <input type="checkbox"/> Referred to eye doctor <input type="checkbox"/> <b>Unable to test – needs rescreen</b>					

<b>Dental Screen</b>	<input type="checkbox"/> Problem Identified: Referred for treatment <input type="checkbox"/> No Problem: Referred for prevention <input type="checkbox"/> No Referral: Already receiving dental care
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<b>Recommendations to (Pre) School, Child Care, or Early Intervention Personnel</b>	<b>Summary of Findings</b> (check one): <input type="checkbox"/> Well child; no conditions identified of concern to school program activities <input type="checkbox"/> Conditions identified that are important to schooling or physical activity (complete sections below and/or explain here): _____ _____ _____ _____	
	___ Allergy <input type="checkbox"/> food: _____ <input type="checkbox"/> insect: _____ <input type="checkbox"/> medicine: _____ <input type="checkbox"/> other: _____ Type of allergic reaction: <input type="checkbox"/> anaphylaxis <input type="checkbox"/> local reaction    Response required: <input type="checkbox"/> none <input type="checkbox"/> epi pen <input type="checkbox"/> other: _____	
	___ Individualized Health Care Plan needed (e.g., asthma, diabetes, seizure disorder, severe allergy, etc) ___ Restricted Activity Specify: _____ ___ Developmental Evaluation <input type="checkbox"/> Has IEP <input type="checkbox"/> Further evaluation needed for: _____	
	___ Medication. Child takes medicine for specific health condition(s). <input type="checkbox"/> Medication must be given and/or available at school.	
	___ Special Diet Specify: _____	
	___ Special Needs Specify: _____	
	___ Other Comments: _____	
	_____ _____ _____	

<b>Health Care Professional's Certification</b> (Write legibly or stamp):		
Name : _____	Signature: _____	Date: ____/____/____
Practice/Clinic Name: _____	Address: _____	
Phone: _____ - _____ - _____	Fax: _____ - _____ - _____	Email: _____

## School Health Entrance Form (2007) Instructions

### **Part I**

Part I is to be completed by the parent or guardian.

Please note that there are three signature lines at the bottom of the page. The first two signatures are required.

1. Inside the box -- signature of the legal guardian or parent: notes authorization for information sharing only.
2. Signature of the person completing the form: this may or may not be the parent or legal guardian; this signature is separate from that authorizing sharing of information.
3. Signature of the Interpreter: needed only if the form was completed with the assistance of an interpreter.

### **Part II**

Instructions for the immunization records are included on the form.

For current immunization requirements consult the Division of Immunization web site at <http://www.vdh.virginia.gov/epidemiology/immunization>

### **Part III**

The Code of Virginia requires documentation of a comprehensive physical examination upon entry to public kindergarten or elementary school. The physical examination must be done by a licensed physician, nurse practitioner, or physician assistant, and must be completed no longer than one year before school entry. The physical examination is required to protect the public from communicable disease, and to identify physical, social-emotional, or developmental needs the child has so that (1) the school can begin to prepare to assist those needs, and (2) necessary interventions can be initiated to maximize the child's school readiness. **For these reasons, in order for a child to be admitted to school without delay, Part I, Part II and -- at minimum -- the Recommendations to (Pre) School, Child Care, or Early Intervention Personnel on Part III must be completed in full.** Local school divisions may require other components. The School Health Entrance Form is also widely used by providers of child care, Head Start, Virginia Preschool Initiative (VPI), and Infant and Toddler Connection (Part C Early Intervention) services. School or other program personnel will contact health care professionals about forms where required sections are incomplete.

The content of the examination is based on *Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents*. Wherever possible, the documentation meets expectations for Early Periodic Screening, Diagnosis, and Treatment (EPSDT) requirements. Web-based continuing education modules on *current* Bright Futures and EPSDT standards are accessible at [www.vcu-cme.org/bf](http://www.vcu-cme.org/bf). Revisions to the content of this training are in process to accommodate the new release of Bright Futures later in 2007.

### ***Health Assessment/Physical Examination***

Refer to Part I as completed by the parent to assist in taking or clarifying the child's history. Checking the boxes for "age/gender appropriate history" and "anticipatory guidance provided" indicates that you have completed these tasks.

Check the appropriate box for each body system examined using the following guide:

1= Within normal limits

2= Abnormal finding

3= Referred for evaluation or treatment (this indicates the provider has made a direct referral to another provider, or advised the parent to follow up with another provider)

**Use the *Recommendations to (Pre) School, Child Care, or Early Intervention Personnel* section to summarize any diagnoses, abnormal findings, or concerns from the physical examination that are of significance.**

Perform a risk screen for tuberculosis considering the following risk factors:

- Exposure to TB or to high risk adults
- TB-like symptoms
- Lived in high prevalence country or extensive travel in areas of high prevalence
- Homelessness or resident in congregate living
- Medically underserved
- HIV infection or receiving immunosuppressive therapy
- Other medical risk factors (i.e., malignancy, diabetes)

If the child is not at risk according to one of these factors, check the box for TB Risk Screen Negative. If the child is at risk, check the box for TB Risk Screen Positive; if you then administer a Mantoux test, document the results in the space provided. Some localities *may require* TB tests on all children for school or other program entry.

**Note:** If completing this form for use in Head Start, EPSDT screening and diagnostic tests apply. This includes: blood lead (test at age 1 and 2, or age 3 if not previously done) and a screen for anemia (hemoglobin or hematocrit annually at ages 2 - 5). Record the specific results and the date of each in the spaces provided. For other children, EPSDT lead or anemia screen, or any significant history of abnormal test results, **may** be noted in this section as information to the personnel reviewing the form.

### ***Developmental Screen***

Screening for age appropriate development is a critical component of well child care and is integral to identifying children who may need assistance in the school or other structured environment. The established standard of well child care recognizes the use of a tool for assessing development. Examples of tools that have been validated and found to be efficient for use in provider offices include: Parent's Evaluation of Developmental Skills (PEDS), Ages and Sages Questionnaires (ASQ), and Child Development Inventories (CDI). Bright Futures milestones are also used in such screening.

Assessment Method: Indicate the tool or method used to evaluate the child. Note the results:

- Check in the column if findings are within the normal range
- Specify any/all concerns identified in the appropriate row/column

- Check if you referred the child for further evaluation (either made a direct referral to another provider, or advised the parent to follow up)

### ***Hearing Screen***

Check the box for the screening method used and indicate the results for each method. Pure tone audiometer should be screened at 20 dB HL in each ear.

Check the boxes as applicable:

- Referred to audiologist/ENT (if child does not pass at the 20 dB level)
- Permanent hearing loss previously identified
- Hearing aid or other assistive device (such as cochlear implant)
- If you are unable to complete a hearing screen check the box “unable to test – needs rescreen”; this will alert school personnel to conduct a hearing screen.

### ***Vision Screen***

Check the box indicated if the test was performed with the child wearing corrective lenses.

Indicate the results of a stereopsis screen, if conducted (up to age 9); check the appropriate box if not.

Indicate the results of the distance acuity screen and note the test used; examples include Snellen letters, Snellen numbers, tumbling E chart, Picture tests, Allen figures. Distance testing at 10 feet is recommended.

Check the boxes as applicable:

- Pass
- Referred to eye doctor (worse than 20/40 with either eye if child is 3 – 5 years old, or 20/30 is 6 years or older, or if there is a two-line difference between the eyes even in the passing range)
- If you are unable to complete a vision screen check the box “unable to test – needs rescreen”; this will alert school personnel to conduct a vision screen.

### ***Dental Screen***

Dental caries (tooth decay) is the most common chronic disease in children. By the time of school entry, all children should be receiving routine preventive care in a dental office (dental home). Perform a visual examination of the mouth, lifting the lip to observe the condition of the gums. Based on your exam, check the appropriate box:

- Problem Identified: Referred for treatment (there are signs of caries, periodontal disease, soft tissue pathology, or a significant abnormal orthodontic condition requiring additional evaluation or corrective intervention in a dental office)
- No Problem: Referred for prevention (there is no evidence of pathology and the mouth appears normal, but the child is not currently receiving routine preventive dental care)
- No Referral: Already receiving care in a dental home (the mouth appears normal, and the child receives regular dental care as reported by the parent). **Note:** the child may have had a single or recent dental visit for an acute problem such as a broken tooth; this alone does not constitute a dental home.

### ***Recommendations to (Pre) School, Child Care, or Early Intervention Personnel***

This box communicates specific information about the child to the school or other program he/she will be entering. It is your opportunity to inform the school/program about this child’s health status, special needs or considerations, and raise any concerns that may help the school/program prepare for the child. ***This box must be completed in order for the form to be accepted by (pre) school personnel.***

**Summary of Findings:** Check the box “Well child; no conditions identified of concern to school program activities” if the findings from your examination and screening are all within normal range, or not significant to the child’s school entry, e.g., an acute upper respiratory infection. Check the box “Conditions identified that are important to schooling or physical activity” if there were any diagnoses or substantive abnormal findings on your examination or screening that should be flagged for school personnel, e.g., asthma, eczema, heart murmur. Use the space provided to summarize such findings from your exam or screenings.

- **Allergy:** Check the type of allergy, specify the allergen, the type of reaction, and the response required.
- **Individualized Health Care Plan Needed:** Note if a Care Plan is needed for any identified condition such as asthma, diabetes, seizure disorder, severe allergy, etc. The parent will need to collaborate with the child’s health care practitioner and provide a Care Plan to school personnel. The Care Plan does not need to accompany this form at the time of enrollment.
- **Restricted Activity:** Indicate any restrictions to physical activity, required assistive devices, or any limitations the child has, of which school personnel need to be aware.
- **Developmental Evaluation:** Note if the child already has an individualized education plan (IEP), or specify any further evaluation needs.
- **Medication:** Note if the child takes medicine, and further note if that medicine must be given or available at school. If this is the case, parents will need to provide the school with authorization. The parent should check with the school for the appropriate form and documentation needed. Authorization does not need to accompany this form at the time of enrollment.
- **Special Diet:** Note special dietary needs that have medical implications, e.g., metabolic restrictions, tube feedings. The parent will need to communicate any special dietary requests to school nutrition services.
- **Special Needs:** Summarize any special health care needs (not otherwise addressed here) of which school personnel should be aware, i.e., oxygen, treatments, etc.
- **Other Comments:** Note any other findings or recommendations that will help school or other program personnel prepare for the child, or assist the child’s family.

***Health Care Professional’s Certification:***

Provide the requested information about the provider who completed the exam and practice location contact information. ***The signature line must be completed;*** a signature stamp is allowed.

Helpful Web Addresses:

<http://www.vahealth.org/schoolhealth/publications.asp>

<http://www.pen.k12.va.us/VDOE/Instruction/Health/home.html>

[http://www.dss.virginia.gov/facility/child\\_care/licensed/child\\_day\\_centers/](http://www.dss.virginia.gov/facility/child_care/licensed/child_day_centers/) -- Virginia Child Day Center regulations

<http://www.headstartva.org/resources/index.htm> -- Additional resources and links, including federal regulations for Head Start

<http://www.vdh.virginia.gov/epidemiology/immunization> -- Immunization schedule/requirements

[www.vcu-cme.org/bf](http://www.vcu-cme.org/bf) -- Bright Futures and EPSDT requirements (under revision 2007)

**WAIVER INFORMATION/RIGHT TO OBJECT**

The Office of Catholic Schools of the Diocese of Arlington (OCS) and any of its schools may produce or participate in videotape, audio recording, Internet (i.e., Website) or still photograph productions that may involve the use of students' names, likenesses, or voices. Such productions may be used for educational and/or school marketing purposes and may be copied or copyrighted with the school retaining any and all rights to such productions.

You have the right to object to the use of your child's name, picture, or voice in these productions and may do so by completing the form below and returning it to the principal of your school. If the form is not returned, we will assume that you waive your right to object.

**SAMPLE**

**PLEASE PRINT**

To: \_\_\_\_\_ (Principal) \_\_\_\_\_ (School)

Regarding: \_\_\_\_\_ (Student)

<u>Activity</u>	<u>Permission Not Granted</u>
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1. Videotaping \_\_\_\_\_

2. Audio Recording \_\_\_\_\_

3. School Pictures \_\_\_\_\_

4. Internet \_\_\_\_\_

5. Television \_\_\_\_\_

6. School Promotional Literature \_\_\_\_\_

7. Other:  
(specify) \_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_  
Student Signature (if 18 or older)

\_\_\_\_\_  
Parent or Guardian Signature  
(if student is under 18)