Gila River
HEALTH CARE

GRIC SCHOOLS
School Yr. 2023-2024

School Health Services
3042 W. Queen Creek Rd, Chandler, AZ 85286

Parents/Guardians,

In order to provide the best care for your child during the 2023-24 school year, you need to complete the enclosed forms in the enrollment packet. Forms to be completed include the following:

SCHOOL HEALTH SERVICES ENROLLMENT PACKET

1. School Health Services-Health Information and Consent to Treat Form. This form is required annually for students attending GRIC schools, in order for your child to receive health services from the school nurse. It also serves as your child's health information and contact information in case of an emergency.
2. Over The Counter Medication Form-required if you would like your student to receive over the counter medication from the school nurse.
3. School Lice Information Sheet: Please contact your nurse for more information.

OPTIONAL COORDINATING WITH GILA RIVER HEALTH CARE DEPARTMENTS CONSENTS FOR THEIR SERVICES

1. Vision Program (Optional) - Your signature is required for Eye Clinic Services during schools hours.
2. Dental Program On-Site Dental Clinic (Optional) - Your signature is required for dental services during school hours.
3. Community Outreach Mobile Unit (Optional) - Your signature is required for community outreach services during school hours. If you have questions related to the services provided on the community outreach mobile unit please contact Robin Henry Family Nurse Practitioner at 520-517-0693.
4. Behavioral Health Services-School Counseling Program (Optional) - Your signature is required for BHS Counseling Program Services during schools hours.
5. Primary Care Audiology Program (Optional) Your signature is required for audiology services during school hours.

Gila River Health Care Contact Information:
Pediatric Department's Ext. 7337
Hu Hu Kam Memorial Hospital (520-562-3321)
Komatke Health Center (520-550-6000)
Hau'pal (Red Tail Hawk) (520-796-2600)
Medical Transportation Department: HHK Ext.1384, KHC Ext.6328 & RTH Ext.1565

If your student will need medical treatments during the school year (inhalers, nebulizer treatments, daily prescribed medication while at school, blood glucose testing), you will need to visit with the School Health nurse. Special arrangements and proper forms must be completed and signed by parent/guardian before treatments/prescribed medication can be given at school.

* *

IMMUNIZATION RECORDS

Please include a current copy of your student's immunization record. It will be required to enroll your student. If your child is missing the required immunizations, they WILL BE EXCLUDED FROM SCHOOL until the needed immunizations are received and documented proof is presented to the school health nurse.

"Healthy children make better students, and better students make healthy communities"

Gila River HEALTH CARE

School Health Services School Year 2023-2024

STUDENT HEALTH INFORMATION SHEET
Gila River Indian Community Schools

Child's Name: _____ Date of Birth: _____ Person ID #: _____ Ⓜ / Ⓕ

Parent/Guardian Name: _____ Lives with: Father / Mother /Guardian Other: _____

Physical Address: _____ Home Phone: _____ Cell: _____ Work: _____

CHILD'S HEALTH HISTORY: Please circle all health conditions that apply to the child:

☐ ADHD	☐ Bleeding Problems	☐ Ear Infections	☐ Heart Surgery date: ____	☐ Seizures
☐ Anemia	☐ Blood Transfusion	☐ Hearing Loss Date: ____	☐ History of Anxiety	☐ Sinus Problems
☐ Asthma	☐ Cold Sores	☐ Heart Murmur	☐ HIV/AIDS	☐ Thyroid Problems
☐ Behavioral Issues	☐ Depression	☐ Hepatitis Type: ____	☐ Lung Problems	☐ TB (Tuberculosis
☐ Bladder/Toileting Problems	☐ Diabetes /Prediabetes	☐ High Blood Pressure	☐ Rheumatic Fever	☐ Other: _____

History of COVID19 (circle): Yes or No

☐ **No Known Allergy**

		(Circle Reaction)	(Epi-Pen Needed)
☐ Yes ☐ No	Food Allergy _____	Rash/Hives or Trouble Breathing	☐ Yes ☐ No
☐ Yes ☐ No	Latex Allergy _____	Rash/Hives or Trouble Breathing	☐ Yes ☐ No
☐ Yes ☐ No	Medication Allergy: _____	Rash/Hives or Trouble Breathing	☐ Yes ☐ No
☐ Yes ☐ No	Other Allergy: _____	Rash/Hives or Trouble Breathing	☐ Yes ☐ No

ANSWER ALL QUESTIONS ABOUT YOUR CHILD'S CURRENT HEALTH-If Yes, please list Reason

☐ Yes ☐ No My child has a **Counselor** or **Case Manager** with GRHC-BHS: **Name:** _____
My child receives behavioral health services from another organization: _____

☐ Yes ☐ No - Is your child currently under medical care? _____

☐ Yes ☐ No - Has your child ever been hospitalized? _____

☐ Yes ☐ No - Past Surgery, please list and date? _____

☐ Yes ☐ No - Activity Restrictions? Please describe: _____

☐ Yes ☐ No - Special Accommodations Needed: _____

☐ Yes ☐ No - Is your child taking any medications at **HOME**? **(List)** _____

☐ Yes ☐ No - Will your child take doctor prescribed **MEDICATION DAILY AT SCHOOL**? **If Yes,** see your school nurse, you must fill out **MEDICATION CONSENT FORM.**
(List Medications) _____

☐ Yes ☐ No My child is supposed to wear glasses? (circle) Full Time Use Part Time Use Reading only

☐ Yes ☐ No My child has seen an eye doctor: **Last Eye Exam Date:** _____ (Glasses Broken/Lost) circle

I understand and agree that it is my responsibility to notify the school nurse and health providers at GRHC of changes in the information recorded on this form. I certify that the information I have provided on this School Health Information form is accurate, true and correct.

✘ _____ ✘ _____ ✘ _____

Print Name of Parent/ Legal Guardian | Signature | Date

All records will be maintained in accordance with the Health Insurance Portability and Accountability Act (HIPAA) and Family Educational Rights and Privacy Act (FERPA), as applicable. By signing this release, you authorize and consent to disclosure of health information on a need-to-know basis for the provision of health care services in accordance with HIPAA and FERPA.

SHS Office Use Only RN Initials: IZ:____ ASIIS:____ MIDAS: _____ NextGEN:____ HIMs:_____

☐ Blackwater Community School ☐ Casa Blanca Community School ☐ St. Peters Indian Catholic Mission
☐ Sacaton Elementary or ☐ Middle School ☐ MVC School ☐ Gila Crossing Elementary or ☐ Middle School

Teacher: _____ **Grade:** _____

GRHC-HIMs Committee Approved Date: 02/15/2023 SHS GRIC Schools Consent School YR 23/24:

Gila River HEALTH CARE

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SCHOOL HEALTH SERVICES CONSENT TO TREAT
Gila River Indian Community Schools

Child's Name: _____ Date of Birth: _____ Person ID #: _____ Ⓜ / Ⓕ

EMERGENCY CONTACTS FOR THE SCHOOL HEALTH NURSE OFFICE: If I am unable to be reached, school authorities have my permission to contact and release my child to the following three individuals if my child becomes ill or is injured:

NAME	Relationship	Phone: Home and Cell
1.		
2.		
3.		

The SHS Program includes, but is not limited to, providing professional nursing services for your child while they attend schools within the Gila River Indian Community. Additional services include health education, annual health screenings, nursing assessments, nursing care and treatment of injury/illness, emergency care, immunization administration and immunization surveillance, infection prevention measures, case-management/care-coordination and monitoring acute and chronic Health conditions.

I understand that in order for my student to receive prescription medication at school, I must sign a SHS Medication Administration Consent form. All medication must be brought to school by an adult, and must be in the original container with the child's prescription label on it. Trained school staff may administer prescribed medication.

If my child experiences a life-threatening anaphylaxis reaction while at school or at a school activity, I understand and give permission for trained school personnel or trained SHS staff to administer life-saving epinephrine medication.

- I understand, Narcan (naloxone hcl) will be available at some schools and will be used when necessary.

In case of accident, or injury/illness, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to contact one of the adults listed above. In the event the adults listed above cannot be reached, the school may make whatever arrangements necessary to provide care and treatment for my child, including call 911. School personnel have my permission to request transport of my child to the nearest emergency room. I understand and agree that I will be responsible for any emergency medical services fees.

SHS Health Educators, will provide health education classes including, but not limited to: the human body, hygiene, emotional and personal health, health careers, health promotion, nutrition, wellness, lice prevention, anti-bullying, infection prevention measures and safety.

I am the parent/guardian of the student listed above and I give consent for my child to receive SHS program services which are explained above. I understand, the SHS Consent to Treat Form is good for the academic school year 2023-24. I understand that if guardianship changes a new consent must be signed by the legal guardian. I understand that by providing an alternative contact, if I cannot be reached, medical information regarding my child, will be shared between the school nurse and the alternative contact.

✘ _____	✘ _____	✘ _____
Print Name of Parent/Legal Guardian	Signature	Date

Gila River HEALTH CARE

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HEALTH INFORMATION RELEASE

Child's Name: _____ Date of Birth: _____ Person ID #: _____ Ⓜ / Ⓕ

- All healthcare information is confidential. By signing this consent form, you are giving the GRHC school nurse permission to communicate and share your child's health information with school personnel about your child's medical condition. Your child's health information will continue to be treated in a confidential manner, and will only be shared with those that need to know for the safety of your child while he/she is at school.

- By signing this consent form, you give us your permission to obtain your child's immunization record, which may include their COVID-19 vaccination record, and share it on a need-to-know basis with school administration.

- By signing this consent form, you give us your permission to obtain your child's COVID-19 test results from their GRHC medical record, and share it on a need-to-know basis with school administration.

- By signing this consent form, you understand and give permission for your child's healthcare information to be shared with other GRHC healthcare providers to coordinate healthcare services and for the continuity of care. The information may include, but is not limited to, COVID-19 test results, eyeglass wear/vision and hearing screening results, and/or other health conditions such as asthma, diabetes, seizures, heart condition(s) or severe allergies.

My signature below indicates that I have read and understand the above, and that the SHS Health Information Release is for the academic year (SY 23-24). I am the legal guardian of the above named child. I understand that if guardianship changes a new consent must be signed by the new legal guardian. I further understand that by providing an alternative contact, if I cannot be reached, medical information regarding the above name child will be shared between the school nurse and the alternative contact.

✘_____ ✘_____ ✘_____

Print Name of Parent/Legal Guardian Signature Date

Gila River HEALTH CARE

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Parent/Guardian Consent for Over The Counter and Non-Prescription Medication Administration During School Hours

There are certain procedures to be followed should it be necessary for your child to be given over the counter medications during school hours. Please review and sign this document.

Child's Name: _____ Date of Birth: _____ Person ID #: _____ Ⓜ / Ⓕ

ADMINISTRATION OF NON-PRESCRIPTION MEDICATION:

OPT OUT ☐ **NO,** I do not want my child to receive Over The Counter Medication at School

Non-prescription medications or over the counter medications (such as Tylenol, bacitracin etc.) may be administered to students who have written permission from parents/guardians. Homeopathic and naturopathic medication will not be administered at the school. Homeopathic and naturopathic remedies are not FDA-approved for use and are therefore not considered as over the counter medications.

A signed Parent/Guardian Consent for Permission to Administer Over the Counter Medications must be signed and on file with the School Health Services Nurse/Office. Non-prescription medications will be given in a dosage consistent with the child's weight and/or age. All medication will be given in accordance with the GRHC SHS Medical Director Standing Order.

OVER-THE-COUNTER MEDICATIONS: I give the School Nurse RN permission to administer the following over the counter medications: **Acetaminophen Tablets and or Chewable Tablet also known as Tylenol, Bacitracin Ointment, Diphenhydramine Capsule and Suspension also known as Benadryl, Hydrocortisone Cream 1%, Refresh Plus-Eye Lubricant (Carboxymethlcellulose sodium 0.5%), Sterile Isotonic Buffered Solution also known as eye wash.**

OVER-THE-COUNTER LICE SHAMPOO:

OPT OUT ☐ **NO,** I do not want a lice shampoo kit for my child.

Rid Lice Shampoo Kit (Piperonyl Butoxide 4% Pyrethrum extract) or GRHC Pharmacy has in stock for lice shampoo.

Is available only to students who are eligible to receive services at GRHC. If my child has been identified as having head lice while at school I, parent/guardian request to be given a lice shampoo kit, so I may treat my child for lice at home. I understand I will need to pick up the lice shampoo kit from the nurse office in person and sign a form verifying I have received a lice shampoo kit.

I understand my child will not be permitted to carry prescribed, herbal medicinal substances or over the counter medications on campus. Student violation of this policy may result in disciplinary action by school administration. The only exceptions are when a parent has signed a self-carrying form for their child. The inhaler and epi-pen must have a prescription label with the student's name on it. This form must be turned into the school nurse prior to self-carrying any medication.

I have read and understand the above and I request and hereby give consent for the GRHC School RN to assist my child with administering over the counter medication (listed above).

Print Name of Parent/Legal Guardian	Signature	Date
✘ _____	✘ _____	✘ _____

Gila River HEALTH CARE

School Health Services School Year 2023-2024

Parent/Guardian CONSENT to TREAT for Additional Health Services (Optional)

Gila River Health Care (GRHC) Departments (page 1 of 3)

Child's Name: _____ Date of Birth: _____ Person ID#: _____ Ⓜ / Ⓕ

Home Phone: _____ Cell phone : _____ Work phone: _____

GRHC- OPTOMETRY:

OPT OUT ☐ NO, I do not want Optometry Services

I GIVE MY CONSENT FOR MY CHILD TO RECEIVE THE FOLLOWING OPTOMETRY SERVICES:

Treatment/Procedure: Complete Eye Exam with possibility of dilation drops to both eyes, 1 hour duration, with the effect of the drops (mild blur and dilated pupils) lasting several hours (which is normal). Not all children will be dilated each year. I authorize school personnel to provide transportation to the Gila River Health Care Optometry Clinic for an eye examination appointment for my child. I understand that my child may have his/her eyes dilated at this appointment. **I also give permission for GRHC Optical staff,** school or school health staff to assist with the selection of frames.

GRHC- Primary Care Department (PCD)-Clinical AUDIOLOGIST:

OPT OUT ☐ NO, I do not want Audiology Services

I GIVE MY CONSENT FOR MY CHILD TO RECEIVE THE FOLLOWING AUDIOLOGY SERVICES:

Treatment/Procedure: Complete hearing test, 30 minutes to 1 hour. I authorize school personnel to provide transportation to the Gila River Health Care Audiology Clinic for a hearing examination appointment for my child. If you have any questions, please direct them to the Audiology Department at GRHC (520)796-2710.

My signature indicates I hereby give consent for my child to receive services from **GRHC Optometry and Audiology. I understand if I select OPT OUT my child will not be seen for services.** I understand this consent is in effect for the following GRHC Departments: Optometry, PCD-Audiology for the academic school year **2023-2024.** I understand and agree that my child's information may be shared with GRHC health care staff and school personnel as needed.

✘ _____ ✘ _____ ✘ _____

Print Name of Parent/Legal Guardian Signature Date

Gila River HEALTH CARE

School Health Services School Year 2023-2024

Parent/Guardian CONSENT to TREAT for Additional Health Services (Optional)

Gila River Health Care (GRHC) Departments (page 2 of 2)

Child's Name: _____ Date of Birth: _____ Person ID #: _____ Ⓜ / Ⓕ

Home Phone: _____ Cell Phone _____ Work phone: _____

GRHC-Dental Services-On Site at Schools: **OPT OUT ☐ NO, I do not want Dental Services**

I GIVE MY CONSENT TO THE FOLLOWING DENTAL SERVICES:

☐ Yes ☐ No– Education Program- Education about tooth decay (cavities), gum disease and prevention.
☐ Yes ☐ No– Dental Exam- X-Rays and examination to identify dental problems requiring treatment.
☐ Yes ☐ No– Dental Screening and Topical Fluoride application to teeth. (A visual inspection of the child's mouth and teeth).
Please note: A Dental Screening is **NOT** the same as a Dental Exam. Patients will be referred to the Dental Clinic for a comprehensive Dental Examination with x-rays.
☐ Yes ☐ No– Dental Cleaning & Sealants- plastic coatings to seal teeth & keep bacteria out to prevent cavities.
☐ Yes ☐ No– Root canals, fillings, crowns, removal of baby teeth, use of local anesthesia (numbing)

All dental services are being provided by GRHC. All treatment supervised by licensed/credentialed Dentist/Dentist specialist. The school is not responsible or liable for any care rendered on site. All services are optional and require written consent as outlined above. A new consent may be submitted at any time if you change your mind regarding level of services to be rendered. If you have any questions, please direct them to Director of Dental Services GRHC (602)528-1209.

☐ Yes ☐ No- Does your child have any **MEDICAL or HEART CONDITION** that **may require medication before dental treatment?** If so, list the medical reasons _____

GRHC-Community Outreach Mobile Unit (COMU) On Site at Schools: **OPT OUT ☐ NO, I do not want COMU Services**

I GIVE MY CONSENT TO THE FOLLOWING COMU SERVICES:

Immunizations, Acute and Chronic Care visits, Well Child Checks, Sports Physicals, Labs, Diabetes screening and/or follow up. I hereby give consent for my child to receive medical care by the Gila River Health Care Community Outreach Mobile Unit Family Nurse Practitioner. I understand that all medical treatment plans will be discussed with me and sent home with the patient. I also understand that I may be able to reach the Family Nurse Practitioner through her work cell phone at (520) 517-0693 with any questions or concerns.

My signature indicates I hereby give consent for my child to receive services from **GRHC Dental and COMU. I understand if I select OPT OUT my child will not be seen for services.** I understand this consent is in effect for the following GRHC Departments: Dental Mobile Unit and COMU for the academic school year **2023-2024.** I understand and agree that my child's information may be shared with GRHC health care staff and school personnel as needed.

✘ _____ ✘ _____ ✘ _____

Print Name of Parent/Legal Guardian Signature Date

Gila River HEALTH CARE

School Health Services School Year 2023-2024

Parent/Guardian CONSENT to TREAT for Additional Health Services (Optional)

Gila River Health Care (GRHC) Departments (page 3 of 3)

Child's Name: _____ Date of Birth: _____ Person ID#: _____ Ⓜ / Ⓕ

Parent/Guardian: _____

Home Phone: _____ Cell Phone _____ Work phone: _____

BEHAVIORAL HEALTH SCHOOL COUNSELING PROGRAM (Optional)

Gila River Health Care (GRHC) has established a Behavioral Health School Counseling (BHSC) Program with your child's school to provide support/counseling services during school hours intended to promote social emotional wellness, educational progress and success. If you would like your child to be eligible to receive these services, you will need to complete the "opt in" section below. If you do not want your child to receive these services, you may opt out of the program by completing the "opt out" section below. Your decision to opt in or out of the program will not prevent your child from receiving services in crisis situations.

Please check *ONLY ONE BOX* below

OPT IN TO THE BHSC PROGRAM: (Check only 1 of the 2 boxes)

☐ I want my child to be eligible receive support/counseling services as needed through the BHSC Program.

I authorize the GRHC BHSC Program to provide support/counseling services (in person or through virtual means), to the extent consistent with Program requirements and in coordination with my child's school, when determined appropriate to support my child's social-emotional wellness, educational progress and success.
I understand that if it is determined that my child would benefit from ongoing behavioral health services such as ongoing groups, one-on-one therapy or referrals to other behavioral health services outside the BHSC Program, such services will be discussed with me and a separate consent form will be sent home with my child before any of these services are provided. I authorize the BHSC Program to share my child's information with school personnel only as necessary to facilitate the services hereunder (including providing a copy of this form to the school) and to protect the health and safety of my child and others.

OPT OUT OF THE BHSC PROGRAM: (Check only 1 of the 2 boxes)

☐ I do not want my child to be eligible to receive support/counseling services through the BHSC Program. I understand that this means that my child will not receive behavioral health services (except in crisis situations) during school hours for the 2023-2024 school year unless consent is provided at a later time. I authorize the BHSC Program to provide a copy of this form to my child's school.

For questions contact: 520-796-2631 grhcschoolcounseling@grhc.org

✘ _____ ✘ _____ ✘ _____

Print Name of Parent/Legal Guardian Signature Date

Gila River Health Care Contact Information:

Hu Hu Kam Memorial Hospital: 602-528-1200 / 520-562-3321
Komatke Health Center: 520-550-6000
Hau'pal (Red Tail Hawk) Health Center: 520-796-2600