Gila River
HEALTH CARE
School Health Services
3042 W. Queen Creek Rd, Chandler, AZ 85286

GRIC SCHOOLS
School Yr. 2025-2026

Parents/Guardians,

In order to provide the best care for your child during the 2025-26 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 Gila River Health Care Pediatric Department at (602) 528-1200 Ext 7337 for any questions regarding my child's medical care.
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.

Gila River
HEALTH CARE

School Health Services

School Year 2025-2026
Lice Information for Parents/Guardian
Gila River Indian Schools

- I understand it is my responsibility to keep my child's hair free of head lice. I understand I need to have my child's hair cleaned in a timely manner to reduce school absence.

- I will review and follow the schools lice guidelines in my student's school handbook for nits, lice, or head sores related to lice infestation.

- The school nurse or school staff will contact me either by phone or letter if my child is found to have nits, lice, or head sores related to lice infestation. If I treat and comb out my child's hair, I may send my student back to school the next day. A pharmacy referral for lice shampoo, lice treatment options and a 14 day Lice educational flyer will be sent home with my child found to have head lice.

- Any GRHC Pharmacy (HHK, RTH or KHC) will provide a lice shampoo kit at your request, for your child/children who have lice. (You do not need to be seen by a doctor or have a referral).

- In addition, the school nurse office has a lice shampoo kit for a child who has lice. The parent/legal guardian MUST arrive to the nurse office at your child's school and sign a form, then the nurse will provide a lice shampoo kit for your child. Contact the school nurse for more information.

- The Gila River Health Care Public Health Nursing (PHN) Department may assist the family with managing head lice at home at the request of the family and the school nurse can send home a PHN referral as well.

Gila River HEALTH CARE

School Health Services School Year 2025-2026

School site location: BWCS, SES, SMS, CBCS, SPIM, GXES, GXMS, MVCS

STUDENT HEALTH INFORMATION SHEET
Gila River Indian Community Schools

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

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

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 COVID-19 (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 ANY doctor-prescribed **MEDICATION AT SCHOOL?** _____

If Yes, see your school nurse, you must fill out **MEDICATION CONSENT FORMS.**
All medication(s) must be in the original container with a valid (non-expired) pharmacy prescription label.
All medication(s) MUST be brought to the school nurse by an ADULT.

☐ 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 acknowledge that it is my responsibility to inform the school nurse and health providers at GRHC of any change to the information recorded on this form. I certify that the information I have provided on the 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: ____ Teacher: ____

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

Gila River HEALTH CARE

School Health Services School Year 2025-2026

School site location: BWCS, SES, SMS, CBCS, SPIM, GXES, GXMS, MVCS

SCHOOL HEALTH SERVICES CONSENT TO TREAT

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

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 attending schools within the Gila River Indian Community (GRIC). Services include health education, annual health screenings, nursing assessments, nursing care, treatment of injury/illness, emergency care, infection prevention measures, case-management/care coordination, acute and chronic health conditions monitoring, immunization surveillance, and childhood immunization

****If Prescription Medication is Needed While at School:****

A school registered nurse (RN) will assist students with their prescription medication during school hours.

1. A parent or guardian must sign a SHS Medication Administration Record Consent form for each medication required.
2. An adult must deliver the medication to the school nurse's office.
3. The medication must be in its original container and have a valid (non-expired) prescription label with the child's name.
4. Trained staff may assist students in taking their prescription medication while at school.
5. Inhalers and epinephrine auto-injectors (EpiPens) must also have a valid (non-expired) prescription label bearing the student's name.
6. Students may self-carry an inhaler or EpiPen if a parent or legal guardian has signed the SHS self-carry consent form.

****If My Child Experiences a Life-Threatening Emergency While at School:****The school RN or trained school personnel will administer epinephrine for severe anaphylactic allergic reactions when indicated. (911 will be called immediately after administration.) The school RN or trained personnel will administer Naloxone HCL (Narcan) for life-threatening overdoses when indicated. (911 will be called immediately after administration)

Emergency Contact List:I request that the school to contact me in the event of an accident, injury, or illness involving my child. If the school cannot reach me, I authorize them to contact one of the adults listed above. If the school is unable to reach any of the adults on the list, they may make any necessary arrangements to provide care and treatment for my child, including calling 911. I permit school personnel to arrange for the transport of my child to the nearest emergency room as recommended by Gila River Emergency Medical Services. I understand and agree that I will be responsible for any fees associated with emergency medical services.

SHS Health Education Classes:

Include, but not limited to, the human body, hygiene, emotional and personal health, health promotion, nutrition, wellness, lice prevention, anti-bullying, infection prevention measures, safety, puberty, and medical health careers education.

I am the parent/legal guardian of the student listed above, and I give consent for my child to receive the SHS program services for the academic school year 2025-26. I understand that if guardianship changes, the legal guardian must sign a new consent. In the event, I am unable to be reached, the school nurse may share my child's medical condition with the alternative contact listed above.

✘ _____ ✘ _____ ✘ _____

Print Name of Parent/Legal Guardian | Signature | Date

SCHOOL HEALTH SERVICES
HEALTH INFORMATION RELEASE

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

- 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. Your child's health information will continue to be treated confidentially and shared with those on a 'need-to-know basis' for your child's safety while they are at school.

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

- By signing this consent form, you permit the school nurse 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 administrator.

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

I am the parent/legal guardian of the child named above. My signature below indicates that I have read and understand the information above. The SHS Health Information Release is for the academic year (SY 25-26). I understand that if guardianship changes, the legal guardian must sign a new consent.

✘ _____ ✘ _____ ✘ _____

Print Name of Parent/Legal Guardian | Signature | Date

Gila River HEALTH CARE

School Health Services School Year 2025-2026

School site location: BWCS, SES, SMS, CBCS, SPIM, GXES, GXMS, MVCS

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

There are specific procedures when your child is to be given over-the-counter medications during school hours.

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

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

Homeopathic and naturopathic remedies are not FDA-approved; therefore, the nurse will not administer them at school. I understand my child will NOT be permitted to carry prescribed, herbal medicinal substances or over-the-counter medication(s) on campus. Student violation of this policy may result in disciplinary action by the school administration

If your doctor has prescribed over-the-counter medication for your child, the parent/guardian must follow guidelines:

- All medication(s) MUST be in the original container with a valid (non-expired) pharmacy prescription label.
- An ADULT must bring all medication(s) to the school nurse office.
- Check with your pharmacy if you need assistance obtaining medication labels.

OVER-THE-COUNTER MEDICATIONS:

The school nurse's office has the following over-the-counter medications. The GRHC Pharmacy provides them with the following:

Acetaminophen (also known as Tylenol) Tablets and or Chewable Tablets, Bacitracin Ointment, Diphenhydramine (also known as Benadryl) Capsule and Suspension, Hydrocortisone Cream 1%, Refresh Plus-Eye Lubricant (Carboxymethylcellulose sodium 0.5%), Sterile Isotonic Buffered Solution also known as eye wash.

The school nurse will administer over-the-counter medication in a dosage consistent with the child's weight and age.

OVER-THE-COUNTER LICE SHAMPOO:

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

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

Should my child be identified as having head lice while at school, the parent/legal guardian may request a lice shampoo kit. The parent or legal guardian MUST pick up the lice shampoo kit from the nurse's office IN PERSON and sign a form verifying receipt.

I have read and understand the above and permit the GRHC School RN to assist my child with administering over-the-counter medication (listed above).

✘ _____ ✘ _____ ✘ _____

Print Name of Parent/Legal Guardian | Signature | Date

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#: _____ M / F

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.

I understand that at the time of my child's eye exam, emotional wellness screening questions may be asked as required by the provider.

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)796-2965.

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 **2025-2026.** 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 2025-2026

School site location: BWCS, SES, SMS, CBCS, SPIM, GXES, GXMS, MVCS

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 #: _____ M / F

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 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.

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. A parent/legal guardian must be present for COMU patient visits. I understand that all medical treatment plans will be discussed with me and sent home with the patient. I also understand that I may reach Gila River Health Care Pediatric Department at (602) 528-1200 Ext 7337 for any questions regarding my child's medical care.

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 **2025-2026.** 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 2025-2026

School site location: BWCS, SES, SMS, CBCS, SPIM, GXES, GXMS, MVCS

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#: _____ M / F

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 2025-2026 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