GANADO UNIFIED SCHOOL DISTRICT #20

EMERGENCY HEALTH FORM

STUDENT: LAST NAME	FIRST NAME	MIDDLE INITIAL	GENDER [ ] MALE [ ] FEMALE
PARENT/GUARDIAN NAME		HOME PHONE	STUDENT: DATE OF BIRTH
ADDRESS	CITY	STATE	ZIP CODE
MOTHER/GUARDIAN WORK PHONE	MOTHER/GUARDIAN CELL NUMBER	LOCATION OF HOME	
FATHER/GUARDIAN WORK PHONE	FATHER/GUARDIAN CELL NUMBER	LOCATION OF HOME	

EMERGENCY CONTACT (WHEN PARENT/GUARDIAN NOT AVAILABLE)

CONTACT NAME:_____
CONTACT NUMBER:_____
RELATIONSHIP TO STUDENT:_____
LOCATION OF HOME:_____

DOES THIS CONTACT HAVE PERMISSION TO PICK UP AND CARE FOR YOUR CHILD? ____YES ____NO

EMERGENCY CONTACT (WHEN PARENT/GUARDIAN NOT AVAILABLE)

CONTACT NAME:_____
CONTACT NUMBER:_____
RELATIONSHIP TO STUDENT:_____
LOCATION OF HOME:_____

DOES THIS CONTACT HAVE PERMISSION TO PICK UP AND CARE FOR YOUR CHILD? ____YES ____NO

ALLERGIES / MEDICAL CONDITIONS TO BE AWARE OF:

____ALLERGIES
- ____SEASONAL
- ____FOOD (LIST)_____
- ____MEDICATION (LIST)_____
- ____OTHER (EXPLAIN)_____

____ASTHMA IS AN ASTHMA ACTION PLAN NEEDED? ____YES ____NO

____DIABETES

____EPILEPSY

____HEART PROBLEMS

____RECURRING ILLNESS

____OTHER_____

____**NONE**

COMMENTS/SPECIAL INSTRUCTIONS:_____

A PHYSICIAN'S STATEMENT MAY BE REQUESTED IF YOUR CHILD HAS PRESCRIBED MEDICATION(S), MEDICAL CONDITION(S), AND/OR PHYSICAL LIMITATIONS. A MEDICATION CONSENT FORM WILL NEED TO BE COMPLETED AND SIGNED IF YOUR CHILD SHOULD NEED HIS/HER MEDICATION ADMINISTERED WHILE IN SCHOOL.

THE SCHOOL HEALTH OFFICE HAS LIMITS AS TO WHAT MEDICATIONS CAN BE ADMINISTERED TO STUDENTS. LISTED BELOW ARE WHAT IS AVAILABLE IN TREATING MINOR ILLNESSES AND/OR INJURIES THAT MAY OCCUR IN SCHOOL. WITH YOUR PERMISSION, AND AT THE DISCRETION OF THE SCHOOL HEALTH PERSONNEL, PLEASE INDICATE (WITH A CHECK) THE MEDICATIONS YOU GIVE CONSENT TO ADMINISTER.

____YES ____NO ACETAMINOPHEN/TYLENOL

____YES ____NO ORAGEL

____YES ____NO COUGH DROPS/THROAT LOZENGES

____YES ____NO ANTIBIOTIC OINTMENT (FOR MINOR CUTS/SCRAPES)

____YES ____NO IRRIGATING EYE WASH

____YES ____NO ANTIPRURITIC OINMENT (FOR ITCHING)
-BENEDRYL CREAM
-CALADRYL LOTION
-CORTISONE CREAM

AS THE PARENT OR LEGAL GUARDIAN OF THE ABOVE NAMED STUDENT, I ENTRUST THE GANADO UNIFIED SCHOOL DISTRICT'S HEALTH PERSONNEL TO CARE AND PROVIDE FOR MY CHILD'S HEALTH/MEDICAL CARE WHILE IN SCHOOL. IN THE EVENT OF AN EMERGENCY, I GIVE MY CONSENT TO HAVE MY CHILD TRANSPORTED TO SAGE MEMORIAL HOSPITAL BY EMERGENCY MEDICAL TRANSPORT OR SCHOOL PROVIDED TRANSPORTATION. THE SCHOOL HEALTH PERSONNEL HAS MY PERMISSION TO EXECUTE NECESSARY DECISIONS UNTIL MY ARRIVAL. I FURTHER UNDERSTAND THAT THE SCHOOL DISTRICT DOES NOT CARRY HEALTH INSURANCE FOR MY CHILD. FOR THAT REASON, I HAVE PROVIDED THE SCHOOL HEALTH OFFICE WITH THE REQUIRED INFORMATION.

_____
SIGNATURE OF PARENT/LEGAL GUARDIAN

_____
DATE

GANADO UNIFIED SCHOOL DISTRICT NO. 20

HEALTH OFFICE

DEVELOPMENTAL HISTORY FORM

ALL INFORMATION IS KEPT CONFIDENTIAL. **PLEASE FILL OUT THE FORM COMPLETELY.**

SY:_____

NAME OF STUDENT:_____ DATE OF BIRTH:_____

LOCATION OF HOME:_____

A. FAMILY HISTORY

Who ALL lives in the home besides the student:_____

Is there any recent family problems? (Illness, accident, separation, divorce, death):_____

B. BIRTH/HEALTH HISTORY

Condition of infant at birth:_____ Any complications at birth? Explain ____No ____ Yes _____

Does the student have problems with any of the following: (IF YES, PLEASE EXPLAIN)

- Speech ____Yes ____No _____
- Heart ____Yes ____No _____
- Joints ____Yes ____No _____
- Extremities (Arms/Legs) ____Yes ____No _____
- Abdomen ____Yes ____No _____
- Seizures/Convulsions ____Yes ____No _____
- Asthma ____Yes ____No _____
- Ears/Hearing ____Yes ____No _____
- Eyes/Vision ____Yes ____No _____
- Other ____Yes ____No _____

Has student ever been examined by an Eye Doctor? When? ____Yes ____No _____

Does he/she wear glasses? ____Yes ____No _____

Is Eye Prescription up-to-date? ____Yes ____No _____

Has student ever fainted or become unconscious? When? ____Yes ____No _____

Has student ever had a broken bone? Which/When? ____Yes ____No _____

Has student ever had any surgeries? Explain. ____Yes ____No _____

Has student ever been hospitalized? Why/When? ____Yes ____No _____

Has student ever received Special Education Services? Grade/School ____Yes ____No _____

Has student had any of the following childhood diseases/illnesses: When:

- Chicken Pox ____Yes ____No _____
- Measles ____Yes ____No _____
- Mumps ____Yes ____No _____
- Hepatitis A or B ____Yes ____No _____
- Meningitis ____Yes ____No _____
- Pertussis (whooping cough) ____Yes ____No _____

Does student have problems with bedwetting or incontinence? How long? ____Yes ____No _____

Does student have any current behavioral problems? (Mental/Emotional) ____Yes ____No _____

ALL INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE:

_____ _____

Signature of Parent/Legal Guardian Date

POST OFFICE BOX 1757, HWY. 264, GANADO, ARIZONA 86505
INFORMATION/ADMINISTRATION (928) 755-1000 BUSINESS OFFICE (928) 755-1003
PRIMARY SCHOOL (928) 755-1200 INTERMEDIATE SCHOOL (928) 755-1300 MIDDLE SCHOOL (928) 755-1400
HIGH SCHOOL (928) 755-1500

NAVAJO NATION HEALTH FOUNDATION
Sage Memorial Hospital

Child Biographical Data Base

Date_____

Name_____ SMH#_____
Last First M.

Other Name Used_____ Census #_____

[ ] Male [ ] Female Birth date_____ Place of birth _____ SSN#_____

Race_____ Tribe_____ Religion _____

Mailing Address_____ City_____ State_____ Zip_____

Location of Home _____ Home Phone_____

If patient is a student, name of school/College_____ City_____ State_____

Father's Name_____ Birthdate_____ SSN#_____ Census #_____

Place of Employment_____ Occupation_____

Address Employment_____ City_____ State_____ Zip_____ Phone#_____

Insurance Company _____ Group #_____ Union or local #_____

Mother's Name_____ Birthdate_____ SSN#_____ Census #_____

Place of Employment_____ Occupation_____

Address of Employment_____ City_____ State_____ Zip_____ Phone# _____

Insurance Company_____ Group#_____ Union or local # _____

Do you have additional insurance ? [ ] Yes [ ] No If yes, complete the following:

Insurance Co. _____ Name of insured _____ SSN#_____ D.O.B _____

Person to notify in case of emergency_____ Address_____ Relationship_____

Home phone#_____ Work phone#_____ Cellular phone#_____

This form filled out by_____