Fountain-Fort Carson Public Schools
Health Information Form

Dear Parent or Guardian: Please complete this form. This information will help us meet the health care needs of your child it will also help us determine if your child will need additional health services. **All medical information is kept confidential.** If your child's health condition should change please contact your school nurse. ***Please include a copy of your child's immunization record.*** Thank you

STUDENT NAME:	GRADE:	DATE OF BIRTH:
PRIMARY DOCTOR:		PHONE #:
OTHER MD/SPECIALIST:		PHONE #:
HOSPITAL OF CHOICE IN THE EVENT OF EMERGENCY		
WILL YOUR STUDENT RIDE THE BUS? ☐ YES ☐ NO		
DOES YOUR STUDENT HAVE: ☐ IEP ☐ 504 ☐ ILP ☐ NONE OF THESE		
Your signature or submission indicates permission to share your student's health information with the appropriate school and to allow the district to handle emergency medical problems. **Parent/Guardian Signature** **Today's Date**		
My child has a doctor diagnosed medical, mental, or behavioral condition that may affect his/her school day: ☐ Yes ☐ No **(If yes please complete the next section)**		

COMPLETE ALL BOXES THAT APPLY TO YOUR CHILD. Parent or Guardian is responsible for providing the school with any medication. Check with the school to obtain the correct medication and procedure forms.

☐ **ALLERGIES**

Allergy Type:

☐ Food (list food(s)) _____

☐ Insect sting (list insect(s)) _____

☐ Medication (list medication(s)) _____

☐ Other (list) _____

Reactions: (Date of last occurrence if yes)

☐ Coughing ☐ Hives ☐ Rash ☐ Difficulty breathing ☐ Wheezing ☐ Nausea

☐ Local swelling ☐ Generalized swelling ☐ Nausea ☐ Other _____

Currently prescribed medications and treatments:

☐ Oral antihistamine (Benadryl, etc) ☐ EpiPen/EpiPen Jr./Twinject ☐ Other _____

☐ **ASTHMA**

Triggers: ☐ Environmental (i.e. tobacco, dust, pollen, pets, etc.) List:_____

Does your child experience asthma symptoms with exercise? ☐ Yes ☐ No Symptoms:

☐ Chest tightness, discomfort, or pain ☐ Difficulty breathing ☐ Coughing ☐ Wheezing ☐ Other _____

Currently prescribed medications and treatments: _____

_____

Date of last hospitalization related to asthma _____ Date of last emergency room visit related to asthma _____

Does your child have a written asthma management plan? ☐ Yes ☐ No Is Peak Flow monitoring used? ☐ Yes ☐ No

☐ **DIABETES**

Currently prescribed medications and treatments:

☐ Insulin: ☐ Syringe ☐ Pen ☐ Pump

☐ Blood sugar testing Type of monitor:_____

☐ Glucagon ☐ Oral medication(s) List medication(s)_____

☐ **SEIZURE DISORDER**

Type of seizure:

☐ Absence (staring, unresponsive) ☐ Complex Partial ☐ Generalized Tonic-Clonic (Grand Mal/Convulsive)

☐ Other (explain) _____

Physical Education Restrictions: ☐ Yes ☐ No

Medication(s): ☐ Yes ☐ No List medication(s) _____

Date of last _____ seizure Length of seizure

_____

Current, DIAGNOSED BY MD, Health Problems (Please check any of the following)

	Anxiety, Excessive		Kidney Disease
	Arthritis		Liver Disease
	Attention Deficit/Hyperactivity Disorder		Mental Health Concerns
	Autism		Migraine Headaches
	Behavioral Problems		Muscle Disease/Disorder
	Bladder Problems		Nerve Disease/Disorder
	Bone/Joint Disorders		Neurofibromatosis
	Bowel Accidents/Problems		Other Breathing Problems
	Cancer, Tumors and/or Growths		Sickle Cell Disease (not trait)
	Cerebral Palsy		Sinus Problems/Headaches
	Cystic Fibrosis		Skin Disease/Problems
	Depression		Spina Bifida
	Developmental Delays/Difficulties		Spinal Injury
	Dizziness/Fainting Spells		Stomach Disorder
	Ear Disease		Throat Problems
	Eating Disorders/Feeding Problems		Ulcer
	Emotional Problems		Wetting Problems
	Eye Disease		Other (specify)
	Gastric Reflux		
	Heart Problems		
	High Blood Pressure		

MEDICATION(S) ☐ Yes ☐ No (Please list)

Special procedures required (i.e. catheterization, oxygen, gastrostomy feeding, gastrostomy care, tracheostomy care, suctioning) ☐ No ☐ Yes Explain_____.

☐**VISION CONDITIONS** ☐ Contacts/Glasses ☐ Other	☐ **HEARING CONDITIONS** ☐ Hearing Aid(s) ☐ Other _____.

_____ _____

School Nurse Signature Date

MINIMUM NUMBER OF DOSES REQUIRED FOR CERTIFICATE OF IMMUNIZATION
Kindergarten through Grade 12, 2014 - 15

VACCINE	Number of Doses	Grades K-12 (5-18 Years of Age)
		Vaccines administered ≤4 days before the minimum age are valid
Pertussis *DTaP only licensed for students through 6 years of age*	5 to 6	5 **DTaP** (if dose 4 was administered on or after the 4th birthday, the requirement is met). The final dose of DTaP must be administered no sooner than 4 years of age. 1 dose of **Tdap** is required for 6th through 12th grades.
Tetanus/Diphtheria *DT only licensed for students through 6 years of age*	3 to 5	5 **DT** (if dose 4 was administered on or after the 4th birthday, the requirement is met). If student is 7 yrs of age or older, must have 3 appropriately spaced tetanus/diphtheria containing vaccines (DTaP, DT, Td, Tdap) – 4 wks between dose 1 & 2 and 6 months between dose 2 & 3.
Polio (IPV)	3 to 4	4 **IPV** (if dose 3 was administered on or after the 4th birthday, the requirement is met). Final dose must be given no sooner than 4th birthday (BOH rule 7/1/2009). *A laboratory test showing immunity is acceptable.*
Measles/Mumps/Rubella (MMR) *1 dose of Rubella meets requirement*	2	2 **MMR** (1st dose cannot be administered more than 4 days before the 1st birthday). 2 doses required for K through 12th grade. 1 dose of rubella meets the requirement. *A laboratory test showing immunity is acceptable.*
Varicella (Chickenpox) *Documentation of disease from a health care provider (physician, RN or PA) is required.*	1 or 2	The 1st dose cannot be administered more than 4 days before the 1st birthday. 2 **VAR** are required for students K through 7th grades. 1 **VAR** is required for 8th through 12th grades. *A laboratory test showing immunity is acceptable.*
Hepatitis B *Students who have not received 3 doses of Hep B vaccine prior to BOH rule 7/1/09, must follow the minimum intervals recommended by the Advisory Committee on Immunization Practices (ACIP)*	3	**ACIP minimum intervals**: The second dose must be administered at least 4 weeks after the first dose. The third dose must be administered at least 16 weeks after the first dose and at least 8 weeks after the second dose. The final dose is to be administered no sooner than 24 wks or 6 months of age. The 2-dose series is acceptable for ages 11-15. 2 doses can only be accepted using the approved vaccine for the 2-dose series with proper documentation (name of the vaccine, dosage, dates, and interval). *A laboratory test showing immunity is acceptable.*

You must provide one of the following to your child's school in order to comply with the law:

1. A completed Certificate of Immunization certifying that the student has received minimum immunizations as indicated above.

2. If a student's Certificate of Immunization is not up to date, the parent, guardian, or emancipated student has 14 days after notification to provide documentation that the next required immunization was administered and submit a written plan for completion of any additional required immunizations. If the plan is not completed, the student shall be expelled or suspended from school for non-compliance. Exception to this is a shortage of vaccine.

3. Statement of Exemption to Immunization Law printed on the reverse side of the Colorado Department of Public Health and Environment Certificate of Immunization:

a) a ***medical*** exemption signed by licensed physician stating that the student's physical condition is such that immunizations would endanger life or health or is otherwise medically contraindicated; or
b) a ***religious*** exemption signed by the parent, guardian, or emancipated student that the student adheres to a religious belief opposed to immunizations; or
c) a ***personal*** exemption signed by the parent, guardian, or emancipated student that the student adheres to a personal belief opposed to immunizations.

Immunization requirements will be strictly enforced for all students. Students who do not meet the requirements will be denied attendance according to Colorado Revised Statutes 25-4-902.

Colorado Department of Public Health and Environment

To learn where to obtain immunizations free or at low cost call the Family Health Line at 303-692-2229 or 1-800-688-7777.