

2022-23 LNS ANNUAL STUDENT HEALTH CONCERNS DOCUMENT

Student Name: _____ School Year: _____ Grade: _____ Birthdate: _____

If student needs medication during the school day, an *Authorization for Administration of Medication at School Form* is required. Forms must be completed by your Health Care Provider **YEARLY before** medication can be given.

****Does your child have a health condition?** Yes No (* If YES - Must contact nurse*)

My child is up to date on immunizations* Yes No

LIFE-THREATENING CONDITIONS: Must contact school nurse! A healthcare plan with physician signature, current exam and all medications must be in place **every year** with the school before the student can attend school. (See policy 4350).

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|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Life Threatening condition requiring epinephrine auto injector (EPI-PEN):
Life Threatening Allergen(s): _____ |
| <input type="checkbox"/> Asthma: *Inhaler/medications needed at school? <input type="checkbox"/> Yes <input type="checkbox"/> No (Yearly order required- see instructions above)
List symptoms and/or Triggers: _____ |
| <input type="checkbox"/> Diabetes Type ____ My child has: <input type="checkbox"/> insulin pump <input type="checkbox"/> insulin pen <input type="checkbox"/> insulin vial/syringe <input type="checkbox"/> oral medication |
| <input type="checkbox"/> Seizure Disorder Meds used to control seizures: _____ Last seizure on: _____ |
| <input type="checkbox"/> Other life-threatening condition(s): _____ |

SPECIAL HEALTH CARE PLANNING: Check appropriate boxes and contact your school nurse for a health care plan. Treatment order from the doctor is required for most special health care needs other than mobility aids.

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| <input type="checkbox"/> Food Intolerance (non-life threatening) _____ |
| <input type="checkbox"/> Special Health Care Planning- *Treatment order required* Please describe: _____ |
| <input type="checkbox"/> Mobility Aids- My child requires special mobility aids such as a wheelchair, walker: _____ |

HEALTH CONDITIONS: Check any of these conditions which your child has or has had:

- | | |
|----------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|
| <input type="checkbox"/> Heart Problems <i>Please contact nurse</i> | <input type="checkbox"/> Cancer <i>Please contact nurse</i> |
| <input type="checkbox"/> Neuro / Brain Injury <i>Please contact nurse</i> | <input type="checkbox"/> Blood Disorder: _____ |
| <input type="checkbox"/> Hearing: _____ | <input type="checkbox"/> Muscles/Bones: _____ |
| <input type="checkbox"/> Vision: _____ | <input type="checkbox"/> Developmental Condition: _____ |
| <input type="checkbox"/> ADD / ADHD: *Medication at school? <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Other: (please explain) _____ |

Immunizations: (Per Policy 4340 students will be excluded until current vaccination or exemption paperwork is provided.)

Authorization for Emergency Procedure If the guardians named on the registration record cannot be reached at the time of an emergency, and the illness, injury or impairment is determined to be urgent by school authorities/school nurse, I authorize and direct the school authorities to send the student (properly accompanied) to the hospital or doctor most easily accessible. I understand that I will assume full responsibility for the payment of any services rendered.

The above health concerns may be shared with school personnel on a "need to know" basis:

Guardian Signature: _____ **Date:** _____

LNS Student COVID-19 Testing Opt-Out Notice

Dear Parent or Guardian,

Beginning on August 31, 2022 through August 30, 2023, Lummi Nation School will be testing students for COVID-19 if there is any concern for COVID exposure or infection. You may opt out of having your child tested for COVID-19 by completing the *LNS Student COVID-19 Testing Opt-Out Form*, which can be found on the LNS website, LNS main office or requested from the LNS School Nurse.

If you do not complete and return the opt-out form, you will be presumed to have consented to the following:

- I consent for my child to be tested for COVID-19 infection by Lummi Nation School staff or Lummi Tribal Health personnel.
- I understand that collecting a specimen for testing involves inserting a small swab, similar to a cotton swab, into both nostrils.
- I consent that the school may notify my child of the test results.
- I understand that my child may be tested multiple times.
- I understand that school staff performing the test are not acting as my child's medical provider and that testing does not replace treatment by a medical provider.
- I understand that my child's test results and other information may be disclosed to Lummi Nation School staff, Lummi Tribal Health Center, and as otherwise permitted by law.

If you do not wish for your child to be tested, we must receive your completed form no later than August 29, 2022.

If you wish for your child to participate in COVID-19 testing as described above, **no further action is required.**

If you have any questions or concerns, please contact the Lummi Nation School nurse.

K-12 School Nurse

Lummi Nation School

Office: 360-758-4369

Email: Nurses@lummi-k12.org