THE MONARCH SCHOOL
AND INSTITUTE

Health Record: Exam and Immunizations INFORMATION

First Name of Child M.I. Last Name Student Date of Birth

Parent(s) Name(s) Program Level

REQUIREMENTS CHECKLIST

☐ A complete physical exam, vision, hearing and spinal screening must be completed annually for all students.

☐ A TB skin test will be required if a student has been exposed to TB or upon returning from travel outside of U.S.

☐ A copy of immunizations from your physician or Health Department with all of the information below. Texas state law requires that students be fully immunized against specific communicable diseases.

☐ Complete the form below including month, date and year (mm/dd/yy) of immunization, exams and screenings.

Students in non-compliance with Texas State Law will not be allowed to attend classes. If this form is not complete and in our files by August 1, 2018, your child may not start school. For more information about the Texas immunization requirements, visit the Texas Dept. of State Health Services at www.dshs.state.tx.us/immunize.

RECORDS

DTP	POLIO	HIB	PCV	Td/Tdap
1. / /_	1. / /	1. / /	1. /_ /	1. / /
2. / /	2. / /	2. / /	2. / /	
3. ____/____/_____	3. ____/____/_____	3. ____/____/_____	3. ____/_____/_____	**Meningococcal*(MCV4)**
4. / /	4. / /	4. / /	4. / /	1. / /
5. / /				

MEASLES/MUMPS/RUBELLA (MMR)	HEPATITIS B	HEPATITIS A	VARICELLA**
1. ____/____/_____	1. ____/____/_____	1. ____/_____/_____	**(Chickenpox)**
2. ____/____/_____	2. ____/____/_____	2. ____/_____/_____	1. ____/____/_____
	3. ____/____/_____		2. ____/____/_____

ANNUAL PHYSICAL EXAM _____/_____/_____ **ANNUAL HEARING EXAM** _____/_____/_____

ANNUAL EYE EXAM _____/_____/_____ **ANNUAL SPINAL SCREENING** ____/_____/_____

*All students entering 7th grade are required to have one dose of meningococcal vaccine.

**Dates of vaccination or written documentation from physician, parent, or school nurse that the child has had chickenpox or has a demonstrated immunity to varicella and does not require the varicella vaccine.

Note: The Monarch School needs up-to-date immunization records on all students. Please have your doctor fax us a copy of updated shot records whenever your child receives a vaccination.

SIGNATURES

Physician Name (please print) _____

Physician Signature _____ **Date:** _____

Parent/Guardian Signature: _____ **Date:** _____

Legally Authorized Representative* Signature _____

(if the student has a court appointed guardian or conservator, or an agent under a power of attorney or under Chapter 34 of the Texas Family Code)

Student Signature _____

(if student is over the age of 18 and no Legally Authorized Representative is signing on their behalf)

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STUDENT MEDICATION FORM

Please get the information below from your doctor and list all medications that are given at home and school. PLEASE INFORM US OF UPCOMING DOCTORS VISITS SO WE CAN PROVIDE HELPFUL INFORMATION. PLEASE REQUEST, COMPLETE, AND RETURN A NEW CHART IMMEDIATELY UPON A MED CHANGE.

This form must be completed each year and as medicine changes occur.

Student:_____ Person Completing Form: _____Date:_____							***School Only***
Date Started	***Medication Medical Name, Brand Name, & Drug Class Type***	***Dosage & Times***	***Physician Name Specialty***	***Reason For Prescription***	***Observable Target Behavior***	***Side Effects To Look For***	***School Tracking System***

Non-Prescription Medications (Over the Counter / Homeopathic):	***Special Notes (Titration Schedules/Drug Holiday/Etc.)***
Last Doctor Appointment	***Next Doctor Appointment***

If needed, please print another copy of this form and attach for additional medications.

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Request for Administration of Prescription Medications

INFORMATION

School personnel are not permitted to give prescription medication of any kind unless the physician requests so in writing. The doctor's permission and instructions for administration of the medication must be accompanied by written permission of at least one parent. A new form must be completed and turned in prior to changes for in-school medications and/or dosages. **A doctor's signature is required for all prescription medications.**

_____ _____

Student's First Name M.I. Last Name Student's Date of Birth

PRESCRIPTION MEDICATION

1. Medication:_____ Reason for Medication: _____

Form of Medication (check one): □ Tablet □ Capsule □ Liquid □ Ointment □ Other _____

Dosage (amount to be given): _____ Time to be administered _____

Allergies: _____

TO BE COMPLETED BY PHYSICIAN

1. Medical risk of missed dosage:_____

2. Procedure for school personnel to follow if dosage is missed:

☐ Notify Parent ☐ Phone you immediately ☐ Transport child to emergency room ☐ Other (below):

_____

PHYSICIAN SIGNATURE

Physician's Name (Please print) _____ **Phone:** _____

Physician's Signature: _____ **Date:** _____

PARENT/GUARDIAN SIGNATURE(S)

I agree to hold the school harmless for the proper administration of medication provided by the parent/guardian and for adverse drug reactions or side effects. I agree to be responsible for maintaining an adequate supply of medication at the school to meet my child's need. I understand that Monarch does not have medical professionals on staff. With my signature below, I am giving permission for my child's medication to be given by a lay person without a medical degree or highly specialized training in pharmacology.

Parent Name (please print): _____

Parent/Guardian Signature: _____ **Date:** _____

Parent Name (please print): _____

Parent/Guardian Signature: _____ **Date:** _____

Legally Authorized Representative* Signature _____

(if the student has a court appointed guardian or conservator, or an agent under a power of attorney or under Chapter 34 of the Texas Family Code)

Student Signature _____

(if student is over the age of 18 and no Legally Authorized Representative is signing on their behalf)

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Request for In-school Administration of Non-prescription Medications

INFORMATION

School personnel are not permitted to give non-prescription medication of any kind, including meds such as Tylenol, Neosporin, etc., without a completed request form from the parent/guardian of the student. **All non-prescription/over-the-counter medicine must be brought to the office with the student's name printed on the container by the parents.**

_____ _____
Student's First Name M.I. Last Name Student's Date of Birth

_____ _____
Parent Name Parent Name

_____
Allergies

NON-PRESCRIPTION MEDICATIONS

1. Medication:_____ Reason for Medication: _____

Form of Medication (check one): ☐ Tablet ☐ Capsule ☐ Liquid ☐ Ointment ☐ Other _____

Dosage (amount to be given): _____Time to be administered _____

2. Medication:_____ Reason for Medication: _____

Form of Medication (check one): □ Tablet □ Capsule □ Liquid □ Ointment □ Other _____

Dosage (amount to be given): _____Time to be administered _____

3. Medication:_____ Reason for Medication: _____

Form of Medication (check one): ☐ Tablet ☐ Capsule ☐ Liquid ☐ Ointment ☐ Other _____

Dosage (amount to be given): _____Time to be administered _____

PARENT PROVIDED PROTECTIVE SUBSTANCES

I will provide the following substances to be administered by school faculty to protect my student:
(If approved for use this must be supplied by parent)

Sunscreen (check one) ☐ Please administer ☐ Do not administer

Insect Repellent (check one) ☐ Please administer ☐ Do not administer

SIGNATURES

Parent/Guardian Signature _____ **Date:** _____

Parent/Guardian Signature: _____ **Date:** _____

Legally Authorized Representative* Signature _____
(if the student has a court appointed guardian or conservator, or an agent under a power of attorney or under Chapter 34 of the Texas Family Code)

Student Signature _____
(if student is over the age of 18 and no Legally Authorized Representative is signing on their behalf)