ANNUAL EMERGENCY INFORMATION RECORD

LAST NAME	FIRST NAME	
GRADE/SCHOOL YEAR	HOME PHONE	DOB

HOME STREET ADDRESS	CITY	STATE	ZIP CODE

MOTHER'S NAME	FATHER'S NAME	EMAIL ADDRESS

MOTHER'S BUSINESS PHONE	MOTHER'S CELL PHONE	FATHER'S BUSINESS PHONE	FATHER'S CELL PHONE

IN CASE OF EMERGENCY AND PARENT IS NOT AVAILABLE, CONTACT:

NAME:_____ RELATIONSHIP:_____ HOME #:_____ DAYTIME #:_____ CELL #:_____

NAME:_____ RELATIONSHIP:_____ HOME #:_____ DAYTIME #:_____ CELL #:_____

STUDENT'S PHYSICIAN	CLINIC	PHONE

ALLERGIES AND OTHER MEDICAL CONDITIONS: (Please explain checked items below or, if necessary, use other side of paper.)

☐ ALLERGIES ☐ ASTHMA ☐ DIABETES

☐ EPILEPSY ☐ HEART PROBLEMS ☐ RECURRING ILLNESS

☐ OTHER CONCERNS (Please list) _____.

Does your child wear glasses, contacts, PE tubes, or hearing aids? If yes, please specify. _____.

Does your child take any medications at home? Please list med and reason for taking it. _____

_____.

Does your child have any restrictions on school related activities such as gym, sports or diet? _____.

In case of an accident or serious illness, I request the school contact me. If the school is unable to reach me, I hereby authorize the school to call the physician indicated and to follow his/her instructions. If it is impossible to contact the physician, the school may make whatever arrangements seem necessary. I will not hold the school district financially responsible for the emergency care and/or transportation for my child.
Your signature also indicates permission to share health information with appropriate medical, school and other support staff (food & bus service), as necessary.

Parent Signature:_____ **Date:** _____

Has your child received any immunizations in the past year? If yes, please provide dates to the school. Please note if you have already done so.
List_____

School Consent to Share Immunization Data – PLEASE READ & SIGN BELOW

MN law (M.S. 144.3351) requires that all students receive immunization to prevent the spread of infectious diseases. The Minnesota Immunization Information Connection (MIIC) collects immunization records from medical clinics, public health and schools in order to help satisfy the requirements of this law. This information is used to help protect your child and prevent the spread of disease in your community. The information can only be shared with those entities allowed by MN law and the information can only be used for immunization record keeping.

The Federal Education Right to Privacy Act (FERPA) requires school to have parental/guardian consent for schools to share your child's immunization record with medical clinics, public health and MIIC in order to satisfy the MN School Immunization Law. Your signature will authorize the School District to release your child's immunization records to your medical provider and to the immunization registry. This information can only be used to improve the quality and timeliness of immunization services and to help schools enforce the School Immunization Law.

☐ I do authorize ☐ I do not authorize

Parent/Guardian Signature:_____ Date: _____

REDWOOD COUNTY PUBLIC HEALTH SERVICE
266 E BRIDGE STREET ♦ REDWOOD FALLS, MN 56283
PHONE 507/637-4041 ♦ FAX 507/637-4046
WEBSITE: http://www.co.redwood.mn.us/County_Departments/Public_Health/public_health.htm

MEDICATION AUTHORIZATION FORM

School: _____

LAST NAME: _____ FIRST NAME: _____ Date of Birth: _____ Grade: _____

DIAGNOSIS/reason for medication: _____ Medical Provider: _____

MEDICATION: _____ ALLERGIES (FOODS OR MEDICINES):

DOSAGE/ROUTE: _____ ☐ NO

TIME/FREQUENCY: _____ ☐ YES & List: _____

DATES COVERED BY ORDER: Begin medication _____ Stop medication: _____

1. I request that the above medication be given during the school day.
2. I release school personnel from any liability in relation to this request when the medication is given as directed above.
3. I authorize the prescriber and school nurse to exchange information when questions arise with regard to this medication or the condition being treated by this medication.
4. I give permission for the nurse to communicate with school & support staff, as necessary, about the action and side effects of this medication.
5. I give permission for the assigned teacher/responsible adult to administer this medication on a field trip, as necessary, following school procedure.

(Cell) _____

* PARENT/GUARDIAN SIGNATURE: _____ Date _____ Phone (Home) _____ (W) _____

MEDICAL PROVIDER AUTHORIZATION (If applicable):

Please ✓ if student is both capable & responsible for SELF-ADMINISTERING this medication: **(subject to school policy)**

☐No ☐Yes Phone _____

* MD/PA/NP Signature _____ Date _____ Fax _____

MEDICATION POLICY

- School District policy states that medication may not be given to a student unless a written request from the parent is received. Each student will need their own form for each medication to be given.
- Prescription medication must be in a properly labeled bottle including the student's name, physician and name , dose and route of the medication to be given.
- Non-prescription medication must be in the original labeled bottle &age appropriate for student. No physician signature is required unless there are indications to do so.

RN-PHN Signature _____ Date _____

1 K
2 new students

Redwood County Public Health

266 East Bridge Street • Redwood Falls, MN 56283
(507) 637-4041 • Fax (507) 637-4046

Dear Parent:

The school district offers a fluoride mouth rinse program to students in grades K - 6. This simple method of applying fluoride has been demonstrated to be safe and effective in controlling tooth decay. Participants will rinse their mouths in school with a 0.2% neutral sodium fluoride solution for one minute once each week under the supervision of their teacher. **This solution is not swallowed.**

This project is very important to the oral health of your child. Participation is entirely voluntary and at no cost to you. We encourage you to allow your child to participate in this valuable health project. This preventive program, however, should not take the place of regular dental care by your dentist.

Please return the completed form to your child's teacher. Your child cannot participate without your **written** consent.

This consent form will be valid until your child completes 6th grade. If you wish to have your child discontinue participation in the program, a written statement is required. If at anytime you would like your child to restart, please let us know.

If you have any questions regarding this project, please call 637-4041.

Sincerely yours,

Redwood County Public Health Service

_____ I WISH my child to participate in the fluoride mouth rinse program.

_____ I DO NOT WISH my child to participate in the fluoride mouth rinse program.

Name of Child: _____ School: _____

Age: _____ Grade: _____

_____ _____
Signature of Parent/Guardian Date

Are Your Kids Ready for School?

Minnesota's School Immunization Law

Directions:

- Find the child's age/grade level and read across to the right.
- Look to see whether the child had the number of shots shown by the checkmark(s) under each vaccine.

Note: Each row is meant to be read separately, so don't add up the columns of checkmarks under each vaccine.

Example: A preschooler needs 4 DTaP, then to enter kindergarten he or she needs 1 more DTaP, for a total of 5 (not 9).

	Hep B hepatitis B	**Tdap/DTaP/Td** diphtheria, tetanus, pertussis (whooping cough)	**Polio**	**MMR** measles, mumps, rubella	**Hib** *Haemophilus influenzae* type b	**Varicella*** (chickenpox)
Preschool (age 3-5)		✓✓✓✓	✓✓✓	✓	At least ✓	✓
Kindergarten**	✓✓✓	✓✓✓✓✓ 5th shot not needed if 4th was after age 4	✓✓✓✓ 4th polio not needed if 3rd was after age 4	✓✓		✓✓
Age 7 through 6th grade		At least ✓✓✓	At least ✓✓✓	✓		
7th through 12th grade	✓✓✓ 7th grade only***	At least ✓✓✓ Plus one more shot at age 11-12 years****	At least ✓✓✓	✓✓		✓✓ 7th grade only

* Varicella shot(s) not required if a child's doctor signs a form saying the child has already had chickenpox disease.

** First graders who are 6 years old and younger must follow the polio and Tdap/DTaP/Td schedules for kindergarten.

*** An alternate 2-shot schedule of hepatitis B may also be used for kids from age 11 through 15 years.

**** If a child received a Td at age 7-10 years they do not necessarily need another one at age 11-12. However, they must receive another shot of Td or Tdap 10 years after their last one.

To go to school in Minnesota, students must show they've had these immunizations or file a legal exemption with the school.

Parents may file a medical exemption signed by a healthcare provider or a conscientious objection signed by a parent/guardian and notarized.

Other immunizations recommended for school kids, but not required by the School Immunization Law:

- Influenza (flu) – each year for children age 6 months through 18 years – especially those with risk factors like asthma and diabetes.
- Hib – an additional two to three doses (depending on the product used) is recommended in addition to the one dose at or after 12 months of age required for school.
- Meningococcal for age 11-18.
- Human papillomavirus (HPV) for girls age 11-18.
- Hepatitis A

MINNESOTA MDH DEPARTMENT of HEALTH
Immunization Program
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-5503 or 1-800-657-3970
www.health.state.mn.us/immunize

IC# 141-0903 (MDH, 6/2011)

Head Injury Teaching Sheet

What are the signs and symptoms of concussion?

Students who experience **one or more** of the signs and symptoms listed below after a bump, blow, or jolt to the head or body be referred to a health care professional experienced in evaluating for concussion.

There is no one single indicator for concussion. Rather, recognizing a concussion requires a symptom assessment. The signs and symptoms of concussion can take time to appear and can become more noticeable during concentration and learning activities in the classroom. For this reason, it is important to watch for changes in how the student is acting or feeling, if symptoms become worse, or if the student just "doesn't feel right."

SIGNS OBSERVED

- Appears dazed or stunned
- Is confused about events
- Answers questions slowly
- Repeats questions
- Can't recall events *prior* to the hit, bump, or fall
- Can't recall events *after* the hit, bump, or fall
- Loses consciousness (even briefly)
- Shows behavior or personality changes

SYMPTOMS REPORTED BY THE STUDENT

Thinking/Remembering:

- Difficulty thinking clearly
- Difficulty concentrating or remembering
- Feeling more slowed down
- Feeling sluggish, hazy, foggy, or groggy

Physical:

- Headache or "pressure" in head
- Nausea or vomiting
- Balance problems or dizziness
- Fatigue or feeling tired
- Blurry or double vision
- Sensitivity to light or noise
- Numbness or tingling
- Does not "feel right"

Emotional:

- Irritable
- Sad
- More emotional than usual
- Nervous

Sleep*:

- Drowsy
- Sleeps *less* than usual
- Sleeps *more* than usual
- Has trouble falling asleep

*Only ask about sleep symptoms if the injury occurred on a prior day.

Remember, you can't see a concussion and some students may not experience or report symptoms until hours or days after the injury. Most young people with a concussion will recover quickly and fully. But for some, concussion signs and symptoms can last for days, weeks, or longer.

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Information from Heads Up to Schools: Know Your Concussion ABC's