

Parents/Guardians: **This form must be completed (Both Sides) each year and returned to the school nurse.**

**Student Health Information Form (envelope provided for mail-in enrollees)**

Student Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Grade \_\_\_\_\_ Date \_\_\_\_\_

Does this student:	Yes	No	Parent/Guardian Comments	Health Room Staff Notations
1. Have a medical diagnosis of a current or chronic health problem (such as diabetes, tuberculosis, seizures, cystic fibrosis, asthma, muscular dystrophy, digestive disorders, etc.) Condition _____ Physician _____				
2. Receive ongoing medication for conditions (ADHD, allergies, asthma, diabetes, depression, anxiety, etc.) Medication _____ Dosage _____ Time Administered _____ Reason for giving _____ ( Fill out Medication Permission form if it needs to be taken at school.)				
3. Known allergies ( food, pollen, animals, medicine, etc) _____ _____				
4. Hearing Concern: Known Condition: _____ Wears Hearing Aid: Yes _____ No _____ Date of last hearing exam: _____				
5. Vision Concern Wears glasses/contacts: Yes _____ No _____ Date of last eye exam: _____				
6. Special instructions for activities, dietary, restroom, etc. _____ _____				

**Junction City Youth Clinic Parent/Guardian Consent Form**

The school nurse has my permission to release \_\_\_\_\_ to the Junction City Youth Clinic for the purpose of obtaining health services. (Name of Student)

Signature \_\_\_\_\_  
 (Parent/Guardian)

Date \_\_\_\_\_

Home Phone \_\_\_\_\_

Business Phone \_\_\_\_\_

## Health Emergency Information

Home Phone for Household: \_\_\_\_\_

Mother/Guardian's Name: \_\_\_\_\_

Mother/Guardian's Cell Phone: \_\_\_\_\_ Mother/Guardian's Work Phone: \_\_\_\_\_

Father/Guardian's Name: \_\_\_\_\_

Father/Guardian's Cell Phone: \_\_\_\_\_ Father/Guardian's Work Phone: \_\_\_\_\_

Local Emergency Contact: \_\_\_\_\_

Emergency Contact's Phone: \_\_\_\_\_

### -----Permission/Release Statements-----

I give consent for my child's immunization information to be shared with/obtained from other schools or health care providers/clinics for the purpose of meeting school health requirements.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

I give my consent for my child's immunization information to be released to the Kansas Immunization Program for the purpose of assessment and reporting.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

I give permission to provide my child's name and other identifying information to the Kansas Department of Health and Environment authorities in the event that my child is suspected of having or is diagnosed with a Kansas reportable communicable disease.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

### **The following information is requested to help provide parents with accurate information about obtaining health care services:**

Type of Health Insurance:

Tri-Care \_\_\_\_\_ Private \_\_\_\_\_ Medicaid \_\_\_\_\_

Health Wave \_\_\_\_\_ None \_\_\_\_\_

Student's Doctor \_\_\_\_\_

Student's Dentist \_\_\_\_\_

# Medication Guidelines for USD 475 Secondary Schools

Fort Riley Middle School, Junction City Middle School, Junction City High School

When possible, medication should be administered at home using a schedule that will not require doses during school hours. However, school personnel will cooperate with parents in circumstances where it is necessary for a student to take **prescription or over-the-counter medication** during the school day.

**Prescription** medication must be sent to school by the parent or guardian in the original pharmacy container with the pharmacy label. The student's name, name of the medication, dosage, date and physician's name must be clearly noted on the label. Any change in time or dosage of medication requires a new prescription from the physician.

**Over-the-counter** medication must be sent to school by the parent or guardian in the original container, marked with the student's name. Only the instructions on the container will be followed (instructions on container must be readable) unless a physician provides alternative instructions.

The following procedures must be followed for medication to be dispensed:

1. The parent or guardian must provide all medications to be administered at school.
2. A medication permission form signed by a parent or guardian must be on file at the school.
3. The first dose of medication must be given at home.
4. All medication must be kept in the health room. It is the student's responsibility to come to the health room for assistance in taking medication.
5. It is recommended that medication that is a controlled substance (Ritalin, Adderall, etc.) be brought to school by the parent or guardian (maximum amount-30 pills or one month supply).

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## Permission Form for Dispensing Prescription or Over-the-Counter Medication

Student Name: \_\_\_\_\_ Grade: \_\_\_\_\_ Team: \_\_\_\_\_ ID# \_\_\_\_\_

Name and Dosage of Medication: \_\_\_\_\_

Time and Duration of Administration: \_\_\_\_\_

Reason for Medication: \_\_\_\_\_

.....

## Permission/Release Statement to be completed by Parent or Guardian

I hereby give permission for designated school personnel to dispense the above named prescription or over-the-counter medication to my child, named above. I certify that he/she has previously had at least one dose of the medication and did not have an adverse reaction from it. I understand that any school employee who administers this medication to my child in accordance with the written instructions from the medication label shall not be liable for damages as a result of an adverse reaction suffered by the student because of administering such drug or because of a mislabeled or altered product. For prescription medication, I hereby authorize a USD #475 school nurse to exchange information with the prescriber and with the pharmacy identified on the affixed pharmacy label.

\_\_\_\_\_ Date

\_\_\_\_\_ Signature of Parent or Guardian



# USD 475 Secondary (Grades 6-12 only) Asthma Medication Permission Form

MUST COMPLETE BOTH SIDES OF FORM WITH PHYSICIAN SIGNATURE REQUIRED

Student Name \_\_\_\_\_ Grade \_\_\_\_\_ ID# \_\_\_\_\_

Medication \_\_\_\_\_ Dosage \_\_\_\_\_

Prescriber's Name \_\_\_\_\_

The above named student has been instructed in and understands the purpose and appropriate method and frequency of use of his/her asthma inhaler.

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\_\_\_\_\_ Student may carry and self-administer inhaler.

## Self-administration Authorization and Disclaimer:

I grant permission for my child to carry and self-administer inhaled asthma medications as prescribed by the physician. I will have on file with the school nurse a physician completed and signed Student Asthma Action Form prior to my child being allowed to carry and self-administer inhaled asthma medications.

I also agree to release the USD 475 school district and all school personnel from any and all claims of liability - including but not limited to my child suffering any adverse reactions from self-carrying and self-administration of inhaled asthma medications.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

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**OR**

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\_\_\_\_\_ Inhaler needs to be kept in the nurse's office and administered per physician orders.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

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## For School Use Only

### Contract Between Student and School Nurse for Student Self-Carry Inhaler

1. Student has demonstrated to the nurse correct use of inhaler.
2. Student agrees to never share the inhaler with another person.
3. Student agrees to go to the nurse if after 2 puffs there is not marked improvement.
4. Student agrees to have the inhaler identified with his/her name on it.

Student Signature \_\_\_\_\_ Date \_\_\_\_\_

Nurse Signature \_\_\_\_\_ Date \_\_\_\_\_

# STUDENT ASTHMA ACTION FORM – *PHYSICIAN SIGNATURE REQUIRED*

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Grade: \_\_\_\_\_ Team: \_\_\_\_\_  
Parent/Guardian: \_\_\_\_\_ Phone: (h): \_\_\_\_\_ (w): \_\_\_\_\_ (c): \_\_\_\_\_  
Parent/Guardian: \_\_\_\_\_ Phone: (h): \_\_\_\_\_ (w): \_\_\_\_\_ (c): \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Phone: (h): \_\_\_\_\_ (w): \_\_\_\_\_ (c): \_\_\_\_\_  
Physician: \_\_\_\_\_ Ph: \_\_\_\_\_

**Asthma Severity** (Required):  Intermittent  Mild Persistent  Moderate Persistent  Severe Persistent

**Asthma Symptom Triggers** (Required):  Exercise  Dust  Pollen/mold  Respiratory Infections  
 Animals  Temperature Change  Strong odors/fumes  Other \_\_\_\_\_

## **EMERGENCY PLAN**

Take Emergency Action for the following symptoms: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_,  
\_\_\_\_\_, \_\_\_\_\_, O<sub>2</sub> Sat of \_\_\_\_\_, or a peak flow of \_\_\_\_\_.

### • Steps to take during an asthma episode:

1. Check O<sub>2</sub> Sat and/or peak flow.
2. Give medications as listed below. Student should respond to treatment in 15-20 minutes.
3. Contact parent/guardian if: \_\_\_\_\_  
\_\_\_\_\_

4. Re-check O<sub>2</sub> Sat and/or peak flow.

5. **SEEK EMERGENCY MEDICAL** care if the student has any of the following:

- ✓ Coughs constantly
- ✓ No improvement 15-20 minutes after initial treatment
- ✓ O<sub>2</sub> Sat of \_\_\_\_\_ and/or peak flow of \_\_\_\_\_
- ✓ Difficulty breathing accompanied by:
  - Chest and neck pulled in with breathing
  - Stooped body posture
  - Struggling or gasping
- ✓ Trouble walking or talking
- ✓ Stops playing and can't start activity again
- ✓ Lips or fingernails are grey or blue



**IF THIS  
HAPPENS, GET  
EMERGENCY HELP  
NOW!**

### • Emergency Asthma Medications (Check all that apply):

Name	Amount	When to Use
1. <input type="checkbox"/> Albuterol Inhaler	2 sprays	15 minutes prior to exercise
2. <input type="checkbox"/> Albuterol Inhaler	2 sprays	very 4 hours prn wheezing, coughing, shortness of breath
3. <input type="checkbox"/> _____	_____	_____
4. <input type="checkbox"/> _____	_____	_____

### • Inhaled Asthma Medications (Check one):

- I have instructed the above named student in the proper administration of his/her medications. It is my professional opinion that he/she should be allowed to self-administer the inhaled medication checked above.
- It is my professional opinion that the above named student should not self-administer his/her medication.

\_\_\_\_\_  
Required Physician Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

**Geary County USD 475  
School Health Services**

School health services are provided by a registered nurse or by school personnel under the direction of a registered nurse. Services include, but are not limited to, health education, emergency care, first aid, evaluation of illness, assistance with securing medical services, communicable disease control, monitoring chronic conditions, administering medication and vision and hearing screening.

It is recommended that parents/guardians screen their children for illness before they are sent to school. Questions regarding health status may be addressed to the school nurse.

Should a student become ill in school, there is a need to have accurate phone numbers at school in order that parents or an alternate person can be contacted immediately. Parents/guardians are responsible for providing transportation for injured or ill students.

**School Health Assessment (Physical Exam):** Every student, age eight and under, entering a Kansas School for the first time, must present the results of a physical exam completed within 12 months of school entry or within 90 days of enrollment. Parents are encouraged to make appointments promptly.

**Immunizations:** The Kansas School Immunization Law requires that each student must have proof of age appropriate immunizations at the time of enrollment.

**Illness and First Aid:** First Aid will be given at school and parents will be informed as necessary. Students may be excluded from school if in the judgment of the school nurse they are suspected of having a communicable disease and/or have an illness or injury that significantly limits their participation in the classroom (Modifications will be made for special circumstances with a note from a doctor). Students should have no vomiting, diarrhea or fever (without medication) for twenty-four hours prior to attending school. Please contact the school if your child is ill and will not be at school.

**Special Health Concern:** Inform the school nurse if your child has specific health problems such as diabetes, seizures, asthma, cerebral palsy, vision or hearing difficulties and/or if your child needs to have medication dispensed at school. The nurse, along with the family, will develop a plan of care. The nurse will inform appropriate faculty and staff of the plan. **If a student cannot fully participate in physical education or recess, a note from a doctor is needed. The note must say what the child cannot do, how long the child cannot participate fully and what type of activity the child can participate in. (Recommend using PE/Activity & Healthcare Provider Share Sheet)**

**Medication:** Medication prescribed by a health care provider will be administered at school with written permission from parent/guardian. Please refer to the USD 475 Medication Guidelines.

**Screenings:** The following screenings are conducted:

Vision: Students in Grades Pre Kindergarten, Kindergarten, 1, 2, 3, 5, 7, 9, 11, and new students annually. Students in special education as required.

Hearing: Students in Grades Pre Kindergarten, Kindergarten, 1, 2, 3, 6, 9, 11, and new students annually. Students in special education as required.

(See reverse side)

**Dental Health:** Preventive dental health education, which emphasizes brushing, flossing, and good nutrition is encouraged.

**Personal Hygiene/Health:** The school needs your support in reinforcing good health habits learned in the classrooms. These include eating a good breakfast each morning, eating nutritious foods, daily physical activity, brushing and flossing teeth, bathing daily, using body deodorant when applicable and wearing clean clothes.

**Junction City Youth Clinic (JCYC):** This clinic serves the needs of youth ages 1-21. The clinic provides physical exams for day care, school, employment and sports. Additional services include, but are not limited to, treating minor illnesses, immunizations, family planning, counseling, and referral services. The Clinic is located at 1018 W. 6<sup>th</sup> Street (785) 762-5022. Students grades 9-12 see JCYC letter for additional information.

**Sickle Cell:** Kansas Law H.B. #2236 requires that you be informed that the nearest facilities that provide counseling and possible testing for sickle cell trait and sickle cell anemia are:

- \*Geary Co. Primary Care Physicians      (785) 238-4131
- \*Junction City Youth Clinic              (785) 762-5022
- \*Geary County Health Department      (785) 762-5788
- \*Konza Prairie Comm. Health Center    (785) 238-4711
- \*Irwin Army Community Hospital        (785) 239-DOCS

# Immunization Requirements for Attendance in USD 475

2008 – 2009 School Year

Kansas law requires that students must show proof of having received all age appropriate immunizations to attend school. Immunizations records from a licensed doctor or health department will be accepted for this requirement.

## Immunizations Required for School Attendance in Grades 6 -12

**DPT, DTaP and/or DT**.....5 doses (4 are adequate if the 4<sup>th</sup> is after the 4<sup>th</sup> Birthday)  
**Td/Tdap** booster is recommended at 11-12 years of age, but **required** 10 years after the last DTaP, usually middle school or high school

**Polio**.....4 doses (3 are adequate if the 3<sup>rd</sup> is after the 4<sup>th</sup> Birthday)

**MMR**.....2 doses (the 1<sup>st</sup> must be after the 1<sup>st</sup> birthday)

Meningitis vaccine is recommended for middle and high school students.  
*Meningitis vaccine is required for entrance to most colleges and to the military.*

## Immunizations Required for School Attendance in Grades Kindergarten-5

Grades K-5 must meet all the requirement for Grades 6-12 **and the following:**  
**Hepatitis B** series .....3 doses (last dose must be after 24 weeks of age)  
**Varicella** (Chickenpox)..... 1 dose required, unless child had Chickenpox  
*Two doses of Varicella are recommended for all students*

## Immunizations Required for School Attendance for Pre-K (ages 3-4)

**DPT, DTaP and/or DT**.....4 doses  
**Polio**.....3 doses  
**MMR**.....1 dose (after 1<sup>st</sup> birthday)  
**Hepatitis B** series and **Varicella** (Chickenpox)

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**A school nurse will review immunization records for these and other requirements (spacing of shots)**

Immunizations may be obtained from:

1. Family Physician
2. Geary County Health Department (762-5788)
3. Junction City Youth Clinic (762-5022)
4. Konza Prairie Community Health Clinic (238-4711)
5. Immunization Clinic at Irwin Army Hospital (Call for an appt. at 239-DOCS)

## Immunization Law

### Article 52. – Health Programs

- 72-5209.1.1.1. **Health tests and inoculations; certification of completion required, alternatives; duties of school boards.** (a) In each school year, every pupil enrolling or enrolled in any school for the first time in this state, and each child enrolling or enrolled for the first time in a preschool or daycare program operated by a school and such other pupils as may be designated by the secretary, prior to admission to and attendance at school, shall present to the appropriate school board certification from a physician or local health department that the pupil has received such tests and inoculations as are deemed necessary by the secretary by such means as are approved by the secretary. Pupils who have not completed the required inoculations may enroll or remain enrolled while completing the required inoculations if a physician or local health department certifies that the pupil has received the most recent appropriate inoculations in all requires series. Failure to timely complete all required series shall be deemed noncompliance.
- (b) As an alternative to the certification required under subsection (a), a pupil shall present:
- (1) An annual written statement signed by a licensed physician stating the physical condition of the child to be such that the tests or inoculations would seriously endanger the life or health of the child, or
  - (2) a written statement signed by one parent or guardian that the child is an adherent of a religious denomination who religious teachings are opposed to such tests or inoculations.
- (c) On or before May 15 of each school year, the school board of every school affected by this act shall notify the parents or guardians of all know pupils who are enrolled or who will be enrolling in the school of the provisions this act and any policy regarding the implementation of the provisions of this act adopted by the school board. (d) If a pupil transfers from one school to another, the school from which the pupil transfers shall forward with the pupil's transcript the certification or statement showing evidence of compliance with the requirements of this act to the school to which the pupil transfers.
- 72/5210. **Same duties of public health departments and officers; fees, exception to payment.** A county, city-county, or multicounty health department shall provide without delay and to the extent that funds are available the test and inoculations required by this act to such pupils as are not provided therewith by their parents or guardians and who have not been exempted on religious or medical grounds. Such tests and inoculations may be provided on a sliding scale for administrative charges with the exception that no child may be denied inoculations for the inability to pay an administrative fee. The local health officer shall counsel and advise school boards concerning the administration of this act.
- Same duties of secretary; forms and certificates; regulations.** The secretary shall prescribe the content of forms and certificates to be used by school boards in carrying out this act and shall provide, without cost to the school boards, sufficient copies of this act for distribution to pupils. Schools shall utilize the reporting form adopted by the secretary for documentation of all immunizations. Audit information shall be obtained from this adopted form. The secretary may adopt such regulations as are necessary to carry out the provisions of this act.



# Junction City Youth Clinic

1018 West 6<sup>th</sup> Street  
Junction City, Kansas 66441

**Public Health**  
Prevent. Promote. Protect.

Website: [www.jcgchealthdept.org](http://www.jcgchealthdept.org)

Patricia Hunter, BSN  
Administrator

2008-2009

## Board Members

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Dear Parents:

The Junction City Youth Clinic was established to provide low cost healthcare services for the children and adolescents of Geary County who attend USD 475. In order to serve more individuals, we have become a Blue Cross Blue Shield contracted provider and are requesting your assistance.

Initially, the Youth Clinic was subsidized by state funds but due to budgetary cuts, it is now wholly self-sustaining. To continue to provider services to our youth, we are requesting that you please provide insurance information for billing purposes.

Many students are sent directly to the Youth Clinic by the school nurse to be seen by our Advanced Registered Nurse Practitioner (ARNP) for minor illness. We are charging a minimal fee for these services. If there is no medical card such as Medicaid, HealthWave, or Blue Cross Blue Shield, we will be sending an invoice to the address provided by the student for services. If no insurance is available, a donation for the services provided is requested. Please notify the office of the Youth Clinic at 785-762-5022 with any insurance information. If no insurance is available, please submit payment.

With your assistance, the Youth Clinic will continue to provide healthcare services on an as needed basis to the children and adolescents of our community.

Sincerely,

*Patricia Hunter*

Patricia Hunter  
Administrator

PH:mjs

Telephone:  
785-762-5022

Facsimile:  
785-762-8601

## **Junction City Youth Clinic (JCYC)**

### Information:

- ✓ A fee of \$18.00 is required for sports physicals. Sports physicals are valid beginning May 1<sup>st</sup> proceeding the school year for which they are needed. Appointments are required for all physicals.
- ✓ If a student is referred to another facility, arrangements need to be made by the parent/guardian for any additional costs.
- ✓ **JCHS students will be released to the clinic during school hours only if a parental/guardian consent form is on file with the school nurse.** (Consent form is on the bottom of the Student Health Information Form.) **Students without written consent form are welcome to visit the clinic before school, during lunch and after school.**
- ✓ A fee is charged for services. If there is no medical card such as Medicaid, Health Wave, or Blue Cross, an invoice will be sent to the address provided by the student for services. If no insurance is available, a donation for the services provided is requested. (See reverse side of paper for letter from the clinic.)
- ✓ The Junction City Youth Clinic is located at 1018 West 6<sup>th</sup> Street. The Clinic is within walking distance from the Junction City High School. Contact the Clinic at 762-5022 for more information or to schedule an appointment.

**\*\*See reverse side for additional information\*\***

**Junction City Youth Clinic  
(JCYC)**