

East Chicago Urban Enterprise Academy



1402 East Chicago Avenue, East Chicago Indiana 46312
Ph # (219) 392-3650 Fax # (219) 392-3652

Enclosed is important information that needs to be read very carefully.

Parents be aware that if you send your child to school with any **undiagnosed rashes, drainage/itching/redness to the eyes, head lice, skin eruptions, elevated temperature, 99.2F or greater**, or anything that can put your child and others at risk, your child will be sent home. The following must be done in order for your child to return to school, **1) submit proof of treatment; 2) obtain freedom from communicable disease note from physician, 3) send note regarding current treatment being done.** If your child has any diagnosed medical condition and/or any need for medication to be given at school, please complete the **Student Physician Form and School Medication Authorization Form.** This information needs to be updated yearly with the school nurse. It is very important that the **Emergency and Illness Information** be completely filled out. On this form include any and all methods of contact available, (cell phone, pager etc.) **In case of a severe emergency**, and you or the emergency contact person cannot be located, your child will be transported by ambulance to the nearest hospital for evaluation. All students in Kindergarten and First grade need to bring an extra change of clothes in their book bags in case they have an accident. If you have any questions please feel free to call (219) 392-3650 extension 239.

Sincerely,
ECUEA Health Staff

Annual Update

Student's Name

Grade

PLEASE COMPLETE CONFIDENTIAL INFORMATION TO BE SHARED WITH TEACHING STAFF

1. Does your child have asthma as diagnosed by a physician? _____. Has your child had any allergic reactions to medications, foods, or insects? _____, if yes, please list care required. _____

2. Has your child been diagnosed hyperactive by your physician? _____. If yes, please list _____

3. Does your child have a seizure disorder as diagnosed by a physician? _____. If yes, please list medication, amount, and time given. _____
4. Has your child been identified as having a bleeding tendency? _____
5. Does your child have diabetes? _____. If so, please list the insulin type, amount, and time given. _____
6. Does your child wear glasses? _____, Contacts? _____
If so, is the correction for near vision difficulties? _____
Or distance vision difficulties? _____
7. Please list any other health concerns you have for your child. _____

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EMERGENCY AND ILLNESS INFORMATION

Important: Return first week of school

Student Name _____ Grade _____ Date of Birth _____ Today's Date _____

Father's Name _____ Mother's Name _____

Student's Address _____
Street City State Zip Code

Home Phone Number _____ Emergency Number _____

Place of Employment

Father _____ Working Hours _____ Business Phone _____

Mother _____ Working Hours _____ Business Phone _____

NAME OF LOCAL PERSON TO CONTACT IF PARENT (S) IS NOT AVAILABLE. (THIS MUST BE COMPLETED)

Name _____ Address _____ Phone _____ Cell _____

HEALTH INFORMATION

DOES YOUR CHILD HAVE ANY UNUSUAL HEALTH CONDITIONS? YES NO

PLEASE CIRCLE:

Asthma	Bee Sting Allergy	Internal Irregularities	Deafness	Physical Handicap (Describe)
Kidney/Bladder	Other Allergy (List)	Convulsive Seizures	Surgical	_____
Arthritis	_____	Sight Impairment	Fractures	Other _____
Diabetes	Mild Severe	Wears Glasses	Heart	_____

PHYSICIAN'S/DENTIST INFORMATION

Family Doctor _____ Office Phone _____

Address _____

Family Dentist _____ Office Phone _____

Address _____

RELEASE

If emergency treatment is required and the parents or legal guardian cannot be reached immediately, your signature in the space provided below empowers the school authorities to exercise their own judgment in calling the physician indicated above, or if not available, to transport the child to a hospital emergency room. Likewise, your signature below is not sufficient for the release of confidential information protected by Federal Law.

Parent/Guardian Signature _____ Date _____

SPECIAL NOTE: Please notify school officials immediately as to changes or modifications to any/all information stated.

**American Quality Schools
East Chicago Urban Enterprise Academy
Medication Policy**

All medication shall be administered by a licensed/registered nurse, Type 73 school nurse or by staff in accordance with their respective licensing requirements.

The school's personnel will administer only prescriptions authorized by a physician. If occasional over-the-counter medication is required, parents may come to the school to administer the medication.

Should the student require daily prescription medication or "as needed" prescriptions for problems such as asthma or allergies, the School Medication Authorization Form must be completed by the attending physician. The parent/guardian must also sign the form. Only medication prescribed by the physician, which are essential for a child to remain in school, will be permitted. Absolutely NO verbal orders from a physician will be accepted.

Prescription medication needed on a short term basis (**for a period of less than 15 days**) following an acute illness, will be permitted provided a School Medication Authorization Form has been completed by a physician and signed by a parent/guardian.

Medication may be administered to the student provided that a Registered Pharmacist from a physician's order fills the prescription.

All medications are to be in a pharmaceutical container, clearly marked with the student's name, physician's name, and pharmacy's name, name of medication, the prescription, dosage, and direction for administering the drug. Any change in medication requires a new School Medication Form in accordance with the above statement.

Occasionally, the student may not be present in the school at the proper time medication is to be dispensed—for example, while attending a field trip. Permission must be given by the physician who ordered the medication to delay the administration of the medication until his/her return to school.

If the physician does not give permission to delay the administration of the medication until returning to the school:

1. The parent/guardian must accompany the student and administer the medication, or
2. The student will not be allowed to participate.

School Medication Authorization forms are available in the office and from the nurse.

Parent Signature: _____

Date: _____

**American Quality Schools Corporation
East Chicago Urban Enterprise Academy**

SCHOOL MEDICATION AUTHORIZATION FORM

STUDENT'S NAME _____ BIRTHDATE _____

ADDRESS _____

SCHOOL _____ GRADE _____ TEACHER _____

HOME PHONE _____ EMERGENCY PHONE# _____

I, _____, parent-guardian of _____,

hereby authorize the American Quality Schools Corporation and it's employees and agents, in behalf and stead, to administer, or my child to self-administer, while under observation of the employees, and agents of the American Quality Schools Corporation, lawfully prescribed medication in the manner described below. I further acknowledge and agree that, when the lawfully prescribed medication is so administered, I waive any claims I might have against the American Quality Schools Corporation; it's employees and agents arising out of the administration of said medication. In addition, I agree to indemnify and hold harmless the American Quality Schools Corporation, it's employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries, including reasonable attorney's fees and costs expended in defense thereof, incurred or resulting from the administration of said medication.

Parent/Guardian Signature

Date

Parents/Guardians: Occasionally children become ill while they are in school or they may have an accident (usually not serious). The school must have on file information that can be used to contact you. Please give the following information for emergency use only. If there is a change in this information, please notify the school quickly in writing.

HEALTH INFORMATION

DOES YOUR CHILD HAVE ANY UNUSUAL HEALTH CONDITIONS? YES NO
IF YES, PLEASE INDICATE:

____ Asthma ____ Bee Sting Allergy ____ Internal Irregularities ____ Deafness ____ Physical Handicap
(Describe) _____

____ Kidney/Bladder ____ Other Allergy (List) ____ Convulsive Seizures ____ Surgical _____

____ Arthritis ____ Sight Impairment ____ Fractures Other _____

____ Diabetes ____ Mild ____ Severe ____ Wears Glasses ____ Heart _____

PARENT/GUARDIAN EMERGENCY INFORMATION #1

NAME _____
HOME NUMBER (____) _____
CELL NUMBER (____) _____
ADDRESS _____
NAME OF EMPLOYER _____
WORK NUMBER _____

PARENT/GUARDIAN EMERGENCY INFORMATION #2

NAME _____
HOME NUMBER (____) _____
CELL NUMBER (____) _____
ADDRESS _____
NAME OF EMPLOYER _____
WORK NUMBER _____

Confidential Information

Is there a current order of protection or No Contact order, which concerns this student: YES NO
School Principal: If yes, is checked, follow the School Board Policy 704A

Please give the name of a relative or neighbor who could be notified in case of illness or accident:

Name _____	Address _____	Telephone _____ (____)	Relationship _____
Name _____	Address _____	Telephone _____ (____)	Relationship _____

If we cannot reach you and feel that your family doctor is needed, please supply this information:

Family Doctor _____ Doctor's Address _____ Doctor's Telephone _____

I authorize you to call my doctor, if necessary _____ (Parent-Guardian Signature)

**American Quality Schools
East Chicago Urban Enterprise Academy**

TO BE COMPLETED BY THE STUDENT'S PHYSICIAN

NAME OF STUDENT _____

NAME OF MEDICATION _____

DOSAGE _____

TIMES TAKEN DURING 24 HOURS _____

REASON FOR MEDICATION _____

MUST THIS MEDICATION BE ADMINISTERED DURING THE SCHOOL DAY FOR THE CRITICAL HEALTH AND WELL-BEING OF THE STUDENT?

YES _____ NO _____

AT WHAT TIME DURING THE SCHOOL DAY MUST IT BE TAKEN? _____

IS THIS CHILD AUTHORIZED TO SELF-ADMINISTER THIS MEDICATION UNDER ADULT SUPERVISION? YES _____ NO _____

LIST THE POSSIBLE SIDE EFFECTS OF THIS MEDICATION _____

LIST ANY OTHER MEDICATION THAT THIS STUDENT IS RECEIVING _____

DIRECTIONS _____

DOCTOR'S NAME (PRINT) _____

DOCTOR'S SIGNATURE _____

DATE _____

DOCTOR'S ADDRESS _____

DOCTOR'S TELEPHONE/EMERGENCY NUMBER _____

I hereby request and give permission to the school nurse or other personnel authorized person to administer the following medication to my child: _____

Parent/Physician request for administration of medication by school personnel

_____ is under my care and should receive _____

Date medication administration begins: _____

Date medication administration ends: _____

Adverse reactions, which should be reported to the doctor: _____

Special instructions for administration: _____

Storage requirements or other conditions: _____

SHOULD A CHANGE IN ANY OF THE ABOVE INFORMATION OCCUR, A REVISED WRITTEN PHYSICIAN'S STATEMENT MUST BE SUBMITTED.

Physician's signature and phone _____

Parent/Guardian signature _____ Date _____

Medication should not be given on the dates circled below.

.....

Aug.	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Sept.	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Oct.	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Nov.	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Dec.	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Jan.	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Feb.	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Mar.	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Apr.	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
May	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
June	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

MEDICATION MUST BE BROUGHT TO SCHOOL IN THE ORIGINAL CONTAINER AS DISPENSED BY THE PHARMACIST OR PHYSICIAN.

If any revisions in the above request occur, a written revised statement must be submitted to the school. In addition, it is the student's responsibility to come to the nurse's office for the medication unless he/she is physically unable to do so.

Parent/Guardian Signature _____ Date _____

The above medication was given as requested by _____
Signature

_____ Date

Title