SOUTHERN UTE INDIAN MONTESSORI ACADEMY

~ HOME OF THE SUIMA EAGLES ~

STUDENT MEDICAL PACKET

Registering for _____
Infant (7 – 18 months)
Toddler (18 – 36 months)
Primary (3 – 6 years)
Elementary I (7 – 12 years)

2ND APPLICATION PROCEDURE NAME: _____

Please submit the following forms to the Southern Ute Indian Montessori Academy.

Forms due:

{ } Consent to Treatment
{ } Medical Examination Record
{ } Medical Statement for Meal Modification
{ } Medication Authorization Form
{ } Fluoride Varnish and Dental Sealant Program
{ } Vision Screening

The Southern Ute Indian Montessori Academy considers the records of all students to be confidential information. Records will only be released to the other schools or agencies upon a signed written request from a parent or guardian.

OFFICE USE ONLY

_____ _____
Date of Enrollment First Day of Class

_____
Teacher and Classroom

_____ _____
Date of Withdrawal Years with SUIMA

_____ _____
School Placement Grade

Referrals Sent: _____
Public: _____
Private: _____

Reason for Leaving: _____

Forwarding Address: _____ Approved By: _____

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Southern Ute Indian Montessori Academy
CONSENT TO TREATMENT

Only designated staff, such as the school nurse or physician will have access to the completed form. This form shall be stored in a locked file.

This form must be filled out at the beginning of each school year to cover the activates for the school year. A copy of each student's form must be taken on off-campus activities.

Student's Name: _____ Date of Birth: ____/_____/_____

Please Print Mo. Day Year

Address: _____

Parent/Guardian Name: _____

Mother/Guardian Business Phone: _____ Home/Cell Phone: _____

Father/Guardian Business Phone: _____ Home/Cell Phone: _____

Please describe allergies to substances and medication: _____

If taking regular medication, please specify: _____

Date of last Tetanus Shot: _____

Please give the name of your local family physician to be called in case your son/daughter becomes ill or has an accident at school and you cannot be reached:

Family Physician: _____ Office Phone: _____

Address: _____

Local Hospital Preference: _____ Phone No.: _____

Please give the names of two relatives or friends who have consented to assume responsibility of your son/daughter in case of illness or accident until you can be reached. **In case of any changes in the named person, notify the school in writing.**

1. Name _____ Phone No.: _____

2. Name _____ Phone No.: _____

Please Sign Back of Page

Authorization and consent to first aid and medical care and release. I hereby knowingly and voluntarily grant my permission to the Academy to authorize and provide first aid and medical treatment of my child if deemed necessary by the Academy, in accordance with the Academy's First Aid and Emergency Medical Care Policy, a copy of which I have received. Furthermore, I consent to such treatment whether provided by Academy personnel, Emergency Medical Technicians, the Southern Ute Health Clinic, or other duly trained staff or medical professionals. I understand that I will be notified by the Academy as soon as possible regarding any situation that may require medical treatment. I agree to be responsible for any charges associated with medical care provided to my child and, if I am unable or unavailable to pick up my child from those providing medical care, I hereby authorize such providers to release my child back to the Academy after providing any necessary medical treatment. For myself, my child and my heirs, I hereby waive and release the Tribe, its Tribal Council Members, appointed officials, employees, and agents and the Academy and its employees (collectively "released parties") from all claims, liabilities, causes of action and damages, except for any caused by the gross negligence of the released parties, that arise out of, are connected with, or result from my authorization and consent or the medical treatment provided in accordance with such authorization and consent.

_____

Parent/Guardian Print Name

_____ _____

Parent/Guardian Signature Date

Southern Ute Indian Montessori Academy
MEDICAL EXAMINATION RECORD

(Have your pediatrician fill out and sign this form)

Please return to the parent/guardian of the below noted child:

Child's Name _____

I have this day given _____ a physical examination and find him/her to be in _____ health.

	Satisfactory	Needs Attention
1. Vision	_____	_____
2. Hearing	_____	_____
3. Dental	_____	_____
4. Nervous System	_____	_____
5. Skin	_____	_____
6. Heart	_____	_____
7. Height	_____	_____
8. Weight	_____	_____

Information: _____

_____

_____

_____

Please attach a copy of the current immunization record.

M.D. Signature _____ Date _____

Address _____

Phone _____

Revised 06/06/22

Southern Ute Indian Montessori Academy
MEDICATION AUTHORIZATION FORM

For standing order medications
(☐Tylenol, ☐ Benadryl, ☐Hydrocortisone Cream, ☐Robitussin)

Student Name: _____ Date of Birth: _____

Grade: _____ Teacher: _____

Name of Medication: _____

Instructions (schedule, dose and route to be given at school): _____

_____

TO BE COMPLETED BY PARENT/GUARDIAN

_____has my permission to receive any or all of the
Student's Name

Above listed medications from the school nurse or the nurse's designee during school hours.

_____ _____
Signature of Parent/Guardian Date

TO BE COMPLETED BY SCHOOL NURSE

Form received in nursing office _____

Medication administration began _____

_____ _____
Signature of School Nurse Date

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Fluoride Varnish and Dental Sealant Program

Dear Parent/Guardian:

A preventive dental program is available through The Southern Ute Dental Clinic. A licensed dental professional can, clean your child's teeth, apply fluoride varnish and apply dental sealants to your child's teeth as a protective measure against tooth decay. To receive this NO-COST service, we must have parental consent for the program.

_____ YES I want my child to receive fluoride varnish and sealant applications.

**If so, please complete the remainder of this form.

_____ NO I do **NOT** want my child to receive fluoride varnish and sealant applications.

Name of Child: _____ Date of Birth: _____

Male: _____ Female: _____

Teacher: _____ Room: _____

Home Address: _____ City: _____ Zip Code: _____

Do you have dental insurance? YES ____ NO ____ If yes, name of insurance: _____

HEALTH HISTORY:

1. Has your child ever had a serious health problem? YES ____ NO ____ If yes, please explain:
   _____
   _____
2. Does your child have any allergies to foods or medicine? YES ____ NO ____ If yes, please list:
   _____
   _____

Parent/Guardian's Name (Please Print): _____

Parent/Guardian's Signature: _____ Date; _____

***This service does not replace a comprehensive dental examination. It is our recommendation a dentist regularly examines and treats your child's dental needs.

FOR OFFICE USE ONLY

Comments: _____

_____

Fluoride placed on: _____ By: _____

Revised 06/06/22

FREE Vision Screening
Colorado Lions KidSight Program

Office Use Only:

SN#_____

Your local Lions Club in conjunction with the Colorado Lions KidSight Program will offer free vision screening to your child at his/her preschool or kindergarten. The screening uses state-of-the-art technology and is 85-90% effective in detecting the vision problems that could lead to lazy eye. No physical contact is made with your child and no eye drops or medications are used. For additional information please visit our website www.kidsightcolorado.org.

WHY VISION SCREENING? *1 in 20 children has an undetected vision problem that could turn into lazy eye if left untreated. Early detection and treatment is essential to prevent lazy eye.*

Parent/Guardian: Please fill out the following. All information is kept confidential and is not sold to third parties.

PLEASE PRINT and ANSWER ALL QUESTIONS

Child's Full Name _____ [_____] Male___ Female___
First Middle Last 3 Initials

Child's Date of Birth _____ Child's Age _____ _____
Month Day Year School Name

Parent or Guardian _____ Email _____

Address _____ City _____ Zip Code _____

Phone INCLUDING area code _____

Is your child under the care of an eye doctor? Yes No If so, name of eye doctor/date of last exam: _____

CONSENT:

I hereby give permission for my child to participate in the screening event. I have read and understand the following information regarding this program:

- The information obtained from this vision screening is preliminary only and does not constitute a diagnosis of vision problems. Not all vision problems are detected by the vision screening process.
- I may be communicated with by telephone if my child does not pass the vision screening.
- I understand that if my child does not pass the eye screening, I am responsible for arranging for an eye exam with an eye doctor of my choice. I understand that I am responsible for all costs of any eye exams.
- I will not hold the Lions organization, KidSight Colorado, their employees, agents, officers, and representatives liable for any injury which may accrue as a result of the vision screening, including but not limited to errors of commission, errors of omission or other misdiagnosis.

_____ _____
Signature of Parent or Guardian Date

VOLUNTEER:

For SureSight Users:

Please ***TAPE*** *Child's Vision Screening Readout at* ***top of edge*** *and label with* ***child's initials*** *and* ***date of birth***

RESULTS: **For Office Use Only**

____**Pass** We are unable to detect a vision problem at this time. This screening is not a substitute for a complete pediatric eye exam. Consult an eye care professional if a vision problem is suspected.

____**Borderline** Your child *may be developing* a mild refractive error that does not need to be formally evaluated at this time. We recommend the child be re-screened by an eye care professional in one year or sooner, if a vision problem is suspected.

___**Unreadable** We were unable to get reliable vision screening results for your child. This can happen occasionally if the child looks away from the blinking light during the screening. Consult an eye care professional if a vision problem is suspected.

____**Refer** Child should be examined by an eye care professional because he/she ***may*** have the following condition:

_____ Strabismus _____ Anisometropia
_____ Astigmatism _____ High Farsightedness
_____ High Myopia _____ Other: _____