NORTHWEST CHRISTIAN SCHOOL
16401 n. 43RD Avenue
Phoenix, AZ 85053
602-978-5134

CONSENT AND RELEASE FOR STUDENT TO CARRY ASTHMA INHALER

_____ (Student) has been instructed in the proper purpose and

appropriate method and frequency of use of the _____ inhaler.

We (Physician) _____ and (Parent) _____,

request that (Student) _____, (Age)_____ be permitted to carry the inhaler on his/her person. We, the undersigned absolve Northwest Christian School of liability if the medication is lost, stolen or abused in any way by the student.

We further note that:

1. The physician has explained, to the parent(s) and student, the detriments and risks of using an inhaler inappropriately.
2. The above named student understands his/her responsibilities for keeping the inhaler safely on his/her person. The above named student understands the importance of preventing other students from using the inhaler, and that such use could seriously endanger other students. As a parent, I have discussed these issues with my child and I believe he/she understands his/her responsibilities for safe inhaler use.
3. As a parent, I understand that as a result of losing his/her inhaler, my child is at risk for a more severe asthmatic crisis.
4. The child/student, his/her parents and physician understand that the usual policy of Northwest Christian School is to keep all medications locked in the school Nurse's Office, for the protection of all students.
5. I understand that the school is not responsible to assist, oversee or supervise my child in the administration of the prescribed medication.

_____ _____

Physician's Name (Please Print) Parent Signature Date

_____ _____

Physician's Signature Date Student Signature Date

_____

Physician's Phone Number

7/04

EMERGENCY HEALTH CARE PLAN

ALLERGY TO: _____

Name: _____ DOB: _____ Teacher: _____

Signs and symptoms of an allergic reaction:

System:	Symptoms:
MOUTH	itching & swelling of the lips, tongue, or mouth
THROAT	itching and/or a sense of tightness in the throat, hoarseness, and hacking cough
SKIN	hives, itchy rash, and/or swelling about the face or extremities
GUT	nausea, abdominal cramps, vomiting, and/or diarrhea
LUNG	shortness of breath, repetitive coughing, and/or wheezing
HEART	"thready" pulse, "passing-out"

The severity of symptoms can quickly change. All above symptoms can potentially progress to a life-threatening situation!

ACTION:

1. If ingestion is suspected, give _____ (medication/dose/route) and _____ immediately!
2. CALL RESCUE SQUAD: 911
3. CALL: Mother _____ Father _____ or emergency contacts.
4. CALL: Dr. _____ at _____

***DO NOT HESITATE TO ADMINISTER MEDICATION OR CALL RESCUE SQUAD EVEN IF PARENTS OR DOCTOR CANNOT BE REACHED!**

_____ _____ _____ _____

Parent Signature | Date | Doctor's Signature | Date

EMERGENCY CONTACTS	TRAINED STAFF MEMBERS
1. _____ Relation _____ Phone: _____	1. _____ Rm
2. _____ Relation _____ Phone: _____	2. _____ Rm ____
	3. _____ Rm ____

☐ Epi-Pen must be with student at all times _____ Signature

☐ Epi-Pen may be kept in Nurse's Office _____ Signature

REQUEST FOR EXEMPTION TO IMMUNIZATION
SCHOOLS (Kindergarten – 12th Grade)

The Arizona Department of Health Services strongly encourages parents to have their children fully immunized to protect not only their children but also other family members, friends, schoolmates, neighbors, and other people in the community. However, if you wish for your child to be exempt from the immunization requirements, this form must be completed, signed and returned to the school. By state law, (A.R.S.§15-873) your child will not be allowed to attend school until either a record of immunization or this exemption statement is submitted. Please indicate below the type of exemption requested and complete all required information. **In the event that the county health department declares an outbreak of a vaccine preventable disease for which you cannot provide proof of immunity for your child, your child will not be allowed to attend school until the risk period ends.**

MEDICAL REASONS - If the immunization would be a health risk to the child because of pre-existing medical conditions, you must sign the statement below *along with your physician's or nurse practitioner's signature*. Your physician or nurse practitioner must state the reason for the medical exemption. The exemption may be for one or more vaccines, and may be either permanent or temporary. If the condition is temporary, the date of its end must be given, at which time the child must receive any necessary vaccine doses.

PERSONAL BELIEFS - If immunizations are against your personal beliefs, you must sign below to exempt your child from the requirements.

LABORATORY EVIDENCE - If your child has previously had a vaccine preventable disease, immunization against that disease is not required if laboratory evidence of immunity signed by a physician or nurse practitioner can be provided. *Copies of lab results must accompany this request.*

COMPLETE AND RETURN THIS FORM TO YOUR CHILD'S SCHOOL

I request an exemption for my child from the required vaccines listed below. I understand the risks and possible outcomes of this decision. I am aware that the disease(s) may result in serious illness, disability or death. I am aware that additional information about immunizations is available from the county health department, the state health department, and from www.immunize.org.

Child's Name _____ Date of Birth_____
(month, day, year)

Type of exemption requested: (Mark one)	For the following vaccines: (Mark all that apply)		
___ Medical** (See below)	___ Diphtheria	___Tetanus	___ Pertussis
___ Personal Beliefs	___ Measles	___ Mumps	___ Rubella
___ Laboratory Evidence	___ Polio	___ Hepatitis B	___ Varicella
	____Meningococcal		

** If a medical exemption is marked, complete the following:

Reason for medical exemption:_____

_____

Length of exemption: Permanent_____Temporary until_____

Required Signatures: A parent or guardian must sign all requests. A physician or nurse practitioner must also sign any requests for medical or laboratory evidence exemptions:

_____	_____
Parent or Guardian	Physician (MD or DO) or Nurse Practitioner
_____	_____
Printed Name	Printed Name
_____	_____
Date: month, day, year	Date: month, day, year