TULSA PUBLIC SCHOOLS

HEALTH SERVICES

DID YOU KNOW?

FACTS ABOUT YOUR SCHOOOL HEALTH CLINIC

Health personnel follow protocols, procedures, and policies developed and/or approved by the Director of Health Services, School Board, Superintendent or his designee. Health Assistants and designated staff are supervised, on health related issues, by a Registered Nurse (RN) and the Director of Health Services.

In order to assist your child with health related needs, you should inform health personnel of:

- specific needs, limitations, restrictions or areas of concern indicated by the doctor, dentist, licensed healthcare facility, or parent,
- all immunizations, boosters, or restrictions obtained from licensed health care providers,
- changes in eye exams and any restriction limitations or accommodations needed,
- medications (prescription and non-prescription) routinely taken at home or school. For medications taken at school, the appropriate forms must be completed, the medication provided by the parent, guardian, or person responsible for student's care,
- absences from school. For your child's safety, call the school office daily to report absences. If your child is absent three (3) or more days, please all or send a note to the school health clinic before the first class, and
- a phone number and emergency number where parent, guardian, or person responsible for student's care can be reached should be on file in the clinic. The health personnel should be immediately notified of changes.

If you have questions or concerns related to your child's health, contact the school health clinic.

HD 2 (Rev. 01/96, 01/97, 04/98)

Keli Edwards
918-925-1510

TULSA PUBLIC SCHOOLS

HEALTH SERVICES

MEDICATION REMINDERS

1. Medication authorization forms must be completed each year for all medications, including inhalers. New forms must be completed if there is a prescription change.

2. Prescription medications must be clearly labeled with the student's name, date, instructions for administration and the physician name.

3. Non-prescription medications (over-the-counter) must be in the original container with instructions for administration, and labeled with the student's name.

4. Students, who are minors, may not transport controlled medications such as Ritalin.

5. For all medications carried by the student, a self-administration form must be completed. The student's physician or dentist must sign the form.

6. Medications left in the school health clinic after the last official day of classes will be discarded according to District policy.

***EXPIRED MEDICATIONS WILL NOT BE ACCEPTED!**

For questions, or a copy of the medication policy, please contact your School Nurse or Health Assistant.

Kelli Edwards
918-925-1510

HD 17B 08/98, 11/02

only fill this out if you have prescription medication to leave in the Clinic.

TULSA PUBLIC SCHOOLS
HEALTH SERVICES

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION BY DESIGNATED SCHOOL PERSONNEL

Oklahoma law states that the school nurse, administrator or other designated school employee shall not be liable to the students, parent or guardian of the student for civil damages for any personal injuries to the student which result from omission of the school nurse, administrator or other designated school employee in administering any medicine pursuant to the provisions of the law except for acts or omissions constituting gross, willful or wanton negligence.

Medication will be given to a student only with the written permission of a parent, the legal guardian or person responsible for student's care. Designated employees may not administer medications requiring invasive routes. Over the counter medications must be in original packaging with printed dosages appropriate for age or weight. Prescription medication must be in a currently dated prescription vial or properly labeled container which correctly states the student's name, the name of the physician or dentist and directions for administering the medication. Aspirin (acetylsalicylic acid) may only be administered with written permission of the physician or dentist. **A new authorization form must be filled out for each change of medication and renewed each school year**. Medication that is not reclaimed by the last official day of school closing will be destroyed, according to policy. The regulations on administering medication to students are available, upon request.

Student Name_____ Birthdate_____

Home Address_____ Telephone _____

School_____ Grade_____ Emergency Telephone_____

PHYSICIAN OR DENTIST ORDER

Diagnosis Requiring Medication_____

Name of Medication #1_____
Time and
amount to be given_____ a.m._____ p.m.

Date: From_____ To _____

Date of Prescription _____ Discontinuation Date_____

Intended Effect of Medication_____
_____

Side effects to Expect_____
to Report_____
If there are side effects, plan of management_____
_____
Is this a controlled drug?_____
(controlled drugs cannot be transported by a minor)
Physician's/Dentist's
Name (Type or Print)_____

Office Phone_____ Emergency Phone_____

Address_____
Physician's/Dentist's
Signature (if required)_____

Diagnosis Requiring Medication_____

Name of Medication #2_____
Time and
Amount to be given_____ a.m._____ p.m.

Date: From_____ To_____

Date of Prescription_____ Discontinuation Date_____

Intended Effect of Medication_____
_____

Side effects to Expect_____
to Report_____
If there are side effects, plan of management_____
_____
Is this a controlled drug?_____
(controlled drugs cannot be transported by a minor)
Physician's/Dentist's
Name (Type or Print)_____

Office Phone_____ Emergency Phone_____

Address_____
Physician's/Dentist's
Signature (if required)_____

AUTHORIZATION BY PARENT/GUARDIAN for the administration of the above medication by school personnel:
I hereby authorize Tulsa Public Schools and its designated employees to administer to my child lawfully prescribed medication in the manner described above.
I ACKNOWLEDGE THAT IT MAY BE PERFORMED BY AN INDIVIDUAL OTHER THAN A SCHOOL NURSE, AND SPECIFICALLY CONSENT TO SUCH PRACTICES. I acknowledge and agree that I waive any claims that I might have against the School District, its employees and agents arising out of the administration of said medicine. I agree to hold harmless its designated employees from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration, attempts at administration or omissions of said medicine pursuant to the provisions of Oklahoma law, except for acts or omissions constituting gross, willful, or wanton negligence. **I further authorize the school nurse and/or designated employee to contact the above named physician(s)/dentist(s) for medical information relevant to the care of the student during school and/or school sponsored activities.**

Signature of Parent/Legal Guardian
or Person Responsible for Student's Care_____ Date_____

Relationship to Student_____ Address_____

Home Phone_____ Emergency Name_____

Work Phone_____ Emergency Phone_____

(see back for additional forms on transporting medication/medical equipment and self-administration of medication)

PARENT/LEGAL CUSTODIAN REQUEST FOR DESIGNATING OWN MINOR CHILD(REN) TO TRANSPORT MEDICATIONS*/MEDICAL EQUIPMENT

The undersigned, the parent(s)/legal custodian(s) of _____ who is enrolled as a student in the _____ grade at _____School, hereby designate my minor child and/or the sibling to bring my child's medication(s) _____ and/or medical equipment _____ to the school health clinic.

***Ritalin and other controlled substances must be transported by an adult.**

_____ _____
Name of Minor Child Relationship to Student

My reason(s) for requesting the exemption is/are as follows:
Remarks:

I understand that by designating my child(ren), I am responsible for any loss, theft, contamination, or inappropriate sharing of the medication(s) and/or medical equipment with other individuals prior to the item(s) reaching a designated staff member of the school. I also understand that if this arrangement creates an undue risk, I will be contacted to review/revise my request.

Date: _____

_____ _____
Parent/Legal Guardian/Person Responsible for Student's Care Parent/Legal Guardian/Person Responsible for Student's Care

_____ _____
Address Address

_____ _____ _____ _____
Nurse's Signature Date Site Administrator's Signature Date

Note: This request shall not extend beyond the current school year

Remarks: _____

CONTRACT FOR EXCEPTION: TO SELF-ADMINISTER AND RETAIN MEDICATION ON PERSON

Date: _____

_____(Child's name) has been instructed in the proper use of the _____ inhaler. We, _____(Physician) and _____ (Parent, Legal Guardian, or Personal Responsible for Student's Care), request that _____ (Child's Name) be permitted to carry the medication on his/her person or to keep same in his/her locker or PE locker, as we consider him/her responsible. He/She has been instructed in and understands the purpose and appropriate method and frequency of use of the medication.

I understand this request is governed by Tulsa Public Schools regulations on self-administration of medication and there are conditions and exceptions to self-administration. I acknowledge I may receive a copy of this regulation, upon request. Also I have instructed my child to inform school personnel if symptoms persist so additional emergency care can be obtained, if needed. I have also been advised to have my child wear a medical alert bracelet and that this permission may be revoked if my child misuses the medication, including permitting other children to use the medication

I understand that the School District, its agents and employees shall incur no liability for any adverse reaction or injury suffered by the student as a result of the self-administration of medication and/or using the specialized equipment.

We, the undersigned, absolve the school of any responsibility in safeguarding our child's medication.

_____ _____ _____ _____
Physician's Signature Date Signature of Parent/Legal Guardian or Person Responsible for Student's Care Date

_____ _____
Signature of Parent/Legal Guardian or Person Responsible for Student's Care Date

***This request shall not extend beyond the end of the current school year.**
****This contract does not apply to Ritalin or any other controlled substance.**

HD 17 Revised 06/91, 07/94, 06/95, 12/95, 07/99, 08/03

Each child needs one form

TULSA PUBLIC SCHOOLS
HEALTH SERVICES

AMBULANCE TRANSPORT:
EMERGENCY MEDICAL INFORMATION
AND AUTHORIZATION TO TREAT & TRANSPORT A MINOR

THIS INFORMATION IS REQUESTED TO ASSIST THE AMBULANCE PERSONNEL IN PROVIDING APPROPRIATE CARE TO THE ABOVE NAMED STUDENT. THE INFORMATION WILL BE RELEASED ONLY TO INDIVIDUALS PROVIDING MEDICAL CARE.

STUDENT'S NAME: _____ BIRTH DATE: _____
ADDRESS/CITY/ZIP: _____
TELEPHONE #: _____ SOC. SEC #: _____

NAME OF PARENT/LEGAL GUARDIAN OR PERSON RESPONSIBLE FOR STUDENT'S CARE:
_____ RELATION: _____
ADDRESS (IF DIFFERENT FROM STUDENT): _____
DAYTIME PHONE #: _____ SOC. SEC #: _____

MEDICAL COVERAGE (CHECK ALL THAT APPLY):
(Note: This does NOT affect the medical care needed)

NONE ____	PRIVATE INSURANCE ____	MEDICAID/ STATE AID ____	EMSA TOTAL CARE ____

INSURANCE CARRIER: _____ POLICY #: _____
MEDICAID # OR SSI #: _____ TOTAL CARE #: _____

STUDENT'S PRIMARY CARE
PHYSICIAN: _____ HOSPITAL PREFERENCE: _____

STUDENT'S ALLERGIES: _____ NONE KNOWN: _____

MEDICAL CONDITION/PAST MEDICAL HISTORY: _____
_____

CURRENT MEDICATIONS & DOSAGES: _____

_____

FOR THE SCHOOL NURSE/OFFICE STAFF

Today's Date: _____

PLEASE NOTE THE PRESENTING PROBLEM OR REPORTED REASON WHICH LED TO CALLING FOR AN AMBULANCE. FOR MEDICAL PROBLEMS, LIST THE SIGNS & SYMPTOMS AND THE TIME OF ONSET. FOR INJURIES, DESCRIBE THE EVENTS PRECEDING THE INJURY, AND ANY WOUNDS OR SIGNS NOTED. IF VITAL SIGNS ARE AVAILABLE, PLEASE INCLUDE THEM HERE WITH THE TIME TAKEN.
THANK YOU!

_____
_____
_____

(over)

TULSA PUBLIC SCHOOLS
Departmento de Servicios de Salud

TRANSPORTE POR AMBULANCIA
INFORMACIÓN MEDICA PARA EMERGENCIA Y
AUTORIZACIÓN PARA PROVEER TRATAMIENTO Y PARA TRANSPORTAR AL EMPLEADO

SE PIDE ESTA INFORMACIÓN PARA AYUDAR AL PERSONAL DE AMBULANCIA EN PROVEER CUIDADO AL EMPLEADO NOMBRADO. ESTA INFORMACIÓN SERA PROVEIDA SOLAMENTE A INDIVIDUOS QUE PROVEEN CUIDADO MEDICO.

NOMBRE Y APELLIDO DEL EMPLEADO: _____ FECHA DE NACIMIENTO: _____
DIRECCIÓN/CIUDAD/CODIGO POSTAL: _____
NUMERO DE TELEFONO: _____ NUMERO DE SEGURO SOCIAL: _____

PERSONA CON QUIEN COMUNICARSE EN CASO DE EMERGENCIA: _____
RELACION: _____
TELEFONO DE DIA PARA COMUNICARSE EN CASO DE EMERGENCIA: _____

PROTECCIÓN MEDICA (INDIQUE LO APLICABLE):
(Note: Esto NO afecta cuidado medico que se necesita)

NADA ____ SEGURO PRIVADO ____ MEDICAID/ AYUDA ESTATAL ____ EMSA TOTAL CARE ____

NOMBRE DEL SEGURO: _____ NUMERO DE POLIZA: _____
DE MEDICAID O DE SEGURO SOCIAL: _____ # DE CUIDADO TOTAL: _____

MEDICO PRINCIPAL: _____ HOSPITAL PREFERENCIA: _____

ALERGIAS: _____ NINGUNA CONOCIDA: _____

CONDICION MEDICA/HISTORIA MEDICA: _____
_____

MEDICINAS Y LAS DOSIS: _____
_____

PARA LA ENFERMERA DE LA ESCUELA/EMPLEADOS DE OFICINA

FECHA DE HOY: _____

FAVOR DE ANOTAR EL PROBLEMA PRESENTE O RAZON POR HABER LLAMADO UNA AMBULANCIA. PARA PROBLEMAS MEDICOS, FAVOR DE INDICAR LOS SINTOMAS Y LA HORA QUE EMPEZARON. PARA LESIONES, DESCRIBA LOS SUCESOS ANTES DEL ACCIDENTE, CUALQUIER LESIONES O DAÑOS NOTADOS. SI SEÑALES VITALES ESTA DISPONIBLES, FAVOR DE INCLUIRLOS Y LA HORA QUE FUERON TOMADOS.

GRACIAS!

_____
_____
_____

(VEA UD. EL OTRO LADO DE LA HOJA)

KG - 1st - 3rd only

NOTICE TO LEGAL GUARDIANS

Oklahoma law states, "The parent or guardian of each student enrolled in kindergarten, first, and third grades at a public school must provide proof that their student passed a vision screening within the last twelve months. No student shall be prohibited from attending school for the lack of a vision screening certification or eye examination report."

If you consent to the vision screening the Health Assistant and/or School Nurse at your site will screen your student free of charge. You will receive the results of the screening and referral recommendations. If you do not have insurance that assists with the costs of corrective glasses, if needed, your student may be eligible to participate in the TPS Health Services Eyeglass Fund, free of charge. The Health Assistant, Nurse, or Health Services, at the Education Service Center, can assist you with details to access the fund.

If you do not want your student screened, please provide proof that a vision screening was passed within the last twelve (12) months. You may use the form below to provide this information.

TULSA PUBLIC SCHOOLS
HEALTH SERVICES

Vision Screening & Comprehensive Eye Exam Certification Form

Please print:

Date: _____

Student's Name: _____
(First) (Middle) (Last)

Please circle: K 1st 3rd

District: _____ School: _____

Complete one of the following:

1. _____ had a vision screening on _____.
(Student Name) (Date)
The screening was administered by _____
(Screener)
_____ was was not referred for a comprehensive eye
(Student Name) (Circle one)
examination by an eye care professional as a results of the above vision screening.

2. _____ had a comprehensive eye examination on _____
(Student Name) (Date)
The comprehensive eye examination was administered by _____.
(Eye Care Professional)

3. _____ has **NOT** received a vision screening or comprehensive eye
(Student Name)
exam in the past twelve months.

_____
(Parent/Guardian Signature

_____
(Date)

***Return to Health Assistant or Nurse at Student's School**

TULSA PUBLIC SCHOOLS
HEALTH SERVICES
CONSENT FOR VISION, HEARING, HEIGHT OR WEIGHT SCREENING

To the Parent, Legal Guardian, or Person Responsible for Student's Care

If you would like your child examined for ☐ Vision ☐ Hearing ☐ Height ☐ Weight on _____ by Tulsa Public School's Health Services personnel, please complete the attached
(date)
consent form. There is no charge for the exam and there is no laboratory work involved. If you would like to be present during the examination, contact the school health clinic to schedule an appointment that is convenient for you. Please return this form to the Health Clinic by _____.
(date)

Referral made by: ☐ Teacher _____
☐ Parent (Signature of Referring Teacher)

Please check any of the following criteria that apply to this student:

VISION:

- ☐ student squints at far distances
- ☐ student squints at close distances or holds book very close
- ☐ student complains of headaches during or after reading
- ☐ student rubs eyes excessively or complains of burning and watering
- ☐ student is unable to see the board or overhead
- ☐ student turns head to use one eye or covers one eye while reading
- ☐ omits letters, words, or phrases
- ☐ complains of seeing double or blurred vision
- ☐ reverses letters (b for d) or words (saw for was)
- ☐ fatigues easily
- ☐ poor eye-hand coordination (i.e. difficulty catching a ball)
- ☐ has a short attention span
- ☐ other _____

HEARING:

- ☐ inattention and frequent mistakes in carrying out instructions
- ☐ faulty articulation, mispronunciation of common words
- ☐ habitual failure to respond when questioned
- ☐ frequent requests for repetition
- ☐ frequent absence with complaint of ear problems
- ☐ discharge in the ear canal
- ☐ cocking head to one side or the other toward sound
- ☐ complaint of dullness, heaviness, or blocked sensation in the ear
- ☐ complaint of pain, tenderness, itching, or heat in or around the ear
- ☐ noises such as buzzing, hissing, or ringing in the ear
- ☐ other _____
(date)

YES

I have read the above information and have had an opportunity to ask questions. I request that the person named below for who I am authorized to sign, be examined by Tulsa Public Schools Health Service's personnel.

_____
Student's Grade and Section

_____ _____ _____
Student's Full Legal Name | Signature of Parent, Legal Guardian, or Person Responsible for Student's Care | Date

NO

I do not want my child screened for ☐ Vision ☐ Hearing ☐ Height ☐ Weight
because of ☐ personal reasons ☐ currently have routine screenings by own doctor If your child has been screened by your own doctor, please complete the certification form on the back of the page.

_____
Student's Grade and Section

_____ _____ _____
Student's Full Legal Name | Signature of Parent, Legal Guardian, or Person Responsible for Student's Care | Date

HD 23E Rev 10/07

AVISO A LOS GUARDINES LEGALES

La Ley de Oklahoma indica, "Los papas o guardianes legales de cada estudiante inscrito en Kinder, primer, y tercer grado en una escuela publica tienen que proporcionar una prueba de que su estudiante paso una revisión de la vista en los últimos doce meses. No se prohibirá a ningún estudiante de atender a la escuela por no tener prueba del examen o el reporte de la revisión de los ojos."

Si conciente para el examen de la visión el asistente de salud y/o la enfermera de la escuela se lo harán al estudiante gratis. Usted recibirá los resultados del examen y un volante de recomendación. Si usted no tiene azeguransa que asista con los costos de los anteojos correctivos, Si los necesita, Su estudiante puede ser elegido para participar en el programa de anteojos del servicio médico de TPS. El asistente de salud, Enfermera, o Servicios Médicos, En el edificio EUCATION SERVICE CENTER, le pueden asistir con la información del programa.

Si usted no quiere que su estudiante sea evaluado, Favor de proporcionar prueba de que a pasado un examen de visión en los últimos doce (12) meses. Usted puede usar la forma de abajo para proporcionar la información.

ESCUELAS PÚBLICAS DE TULSA
SERVISIOS MEDICOS

Forma De Certificación Para El Examen De La Vista Y Prueba Exhaustiva De Los Ojos.

Letra de Molde Por Favor:

Fecha: _____

Nombre del Estudiante:

_____
(Primer nombre) (Segundo nombre) (Apellido)

Por Favor Circule: K 1ro 3ro

Distrito: _____ Escuela: _____

Completar uno de lo siguiente:

1. _____ le han revisado la visión en _____.
   (Nombre del Estudiante) (Fecha)
   La revisión fue administrada por _____
   (Quien lo practico)
   _____ fue no fue referido ah un examen comprensivo
   (Nombre del Estudiante) (Circule uno)
   de la vista por un profesional del cuidado de los ojos como resultado del examen practicado.

2. _____tubo un examen comprensivo de los ojos en _____
   (Nombre del Estudiante) (Fecha)
   EL examen comprensivo fue administrado por _____.
   (Profesional del cuidado de los ojos)
3. _____ NO ah recibido un examen de visión o prueba exhaustiva
   (Nombre del Estudiante)
   de los ojos en los últimos doce meses.

_____
(Padre o tutor)

_____
(Fecha

***Regresar a la enfermera o asistente de salud de la escuela del estudiante.**

LAS ESCUELAS PÚBLICAS DE TULSA
SERVISIOS DE SALUD
CONSENTIMIENTO PARA UN EXAMEN DE VISIÓN, OÍDO, ALTURA Y EL PESO DEL ESTUDIANTE.

Al Padre, Guardián legal o persona responsable del Estudiante:

Si Usted desea un examen para su hijo, de ☐Visión ☐Oído ☐Altura y ☐peso hecho por el Departamento de Salud de Las Escuelas Públicas de Tulsa en esta fecha _____, por favor complete la Aplicación de consentimiento. No hay cobro por este servicio y le aseguramos Que no habrá uso de laboratorio. Si Usted desea estar presente durante el examen, Contacte al la Clínica de Salud de su Escuela y haga una cita con ellos, lo más Pronto que se pueda. Por favor devuelva esta aplicación a nuestra oficina para La fecha indicada aquí. _____.

Referido por: ☐ Maestro _____.
☐ Padre (firma del Maestro)

Por favor marque todo los criterios que apliquen a este estudiante:

VISION:

- ☐ El estudiante escudriña los ojos pare ver lejos.
- ☐ El estudiante escudriña los ojos para ver cerca o se pone los libros muy cerca para leer.
- El estudiante se queja de dolor de cabeza Antes o después de leer.
- ☐ El estudiante se talla los ojos excesivamente o se queja de ardor y le lloran.
- ☐ El estudiante no puede ver la pizarra.
- El estudiante voltea hacía el lodo para usar un ojo o se cubre un ojo cuando lee.
- ☐ Omite letras, palabras, o frases
- ☐ Se queja de ver doble o de visión borrosa
- ☐ Pone letras al revés (b por d) o palabras como (saw por was)
- ☐ Se fatiga muy pronto
- ☐ Coordinación pobre de ojos Con manos como cachar la pelota.
- ☐ Tiene un pasmo de tiempo corto
- ☐ Otro _____

OIDOS:

- ☐ Inatención y errores frecuentes Con instrucciones
- ☐ Mala pronunciación, de palabras comunes
- ☐ Falta habitual de no responder
- ☐ Pide frecuentemente que repitan las cosas
- ☐ Frecuentes ausencias con queja de problemas del oído
- ☐ Descarga en el canal del oído
- ☐ Voltea la cabeza para donde ay sonido
- ☐ Se queja de pesadez, dormido, o sensación bloqueada en el oído
- ☐ Se queja de dolor, picazón, o ardor dentro o alrededor del oído
- ☐ Ruidos como zumbido, silbido u otros ruidos en el oído
- ☐ Otro _____

He leído la información de esta aplicación y he tenido oportunidad de hacer preguntas Acera de este plan, y Yo quiero que el estudiante nombrado en esta aplicación, sea Examinado por el Departamento de Salud de las Escuelas Públicas de Tulsa.

_____
Nombre del Estudiante y Año Escolar

_____ _____ _____
Nombre Legal del Estudiante Firma del Padre o Guardián Legal fecha

---

Yo prefiero que mi hijo NO sea examinado para la ☐Visión ☐ Oído
☐Altura ☐ Peso por las razones siguientes: (marque una) ☐ por rezones personales.
☐Tengo Doctor para mi familia y han tenido un examen de rutina.

Si su estudiante ha tenido un examen por su Doctor de familia por favor llene le forma que esta al reverso de esta hoja.

_____
Nombre del Estudiante y Año Escolar

_____ _____ _____
Nombre Legal del Estudiante Firma del Padre o Guardián Legal Fecha

HD 23E (S) 10/07

Each child needs one form on file

Tulsa Public Schools
HEALTH SERVICES

Date: _____

TO WHOM IT MAY CONCERN:

I (we) do hereby give my (our) permission for the Health Assistant and/or School Nurse to release the health information contained in their files to District personnel who have a need or right to know concerning my child or children listed below:

Name of child _____ Birthdate _____ Grade _____

Name of child _____ Birthdate _____ Grade _____

Name of child _____ Birthdate _____ Grade _____

_____
Parent, Legal Guardian, or Person Responsible for Student's Care

_____
Address

Signed: _____

Relationship: _____

(If more than one (1) child listed, place original consent in file of first child with copies in additional children's files.)

***This consent can be revoked in writing, at any time, and must be renewed annually.**
****Extent of Release and conditions are governed by District Policy, FERPA, and HIPAA requirements.**

Documentation of information released to:

_____ (Name)	_____ (Title)	_____ (Date)
_____ (Name)	_____ (Title)	_____ (Date)
_____ (Name)	_____ (Title)	_____ (Date)

(additional documentation may be listed on back of form)

HD 14 Rev 04/90, 02/04

Each child needs one form

TULSA PUBLIC SCHOOLS
HEALTH SERVICES

AMBULANCE TRANSPORT: EMERGENCY MEDICAL INFORMATION AND AUTHORIZATION TO TREAT & TRANSPORT A MINOR

THIS INFORMATION IS REQUESTED TO ASSIST THE AMBULANCE PERSONNEL IN PROVIDING APPROPRIATE CARE TO THE ABOVE NAMED STUDENT. THE INFORMATION WILL BE RELEASED ONLY TO INDIVIDUALS PROVIDING MEDICAL CARE.

STUDENT'S NAME: _____ BIRTH DATE: _____
ADDRESS/CITY/ZIP: _____
TELEPHONE #: _____ SOC. SEC #: _____

NAME OF PARENT/LEGAL GUARDIAN OR PERSON RESPONSIBLE FOR STUDENT'S CARE:
_____ RELATION: _____
ADDRESS (IF DIFFERENT FROM STUDENT): _____
DAYTIME PHONE #: _____ SOC. SEC #: _____

MEDICAL COVERAGE (CHECK ALL THAT APPLY):
(Note: This does NOT affect the medical care needed)

NONE _____ PRIVATE INSURANCE _____ MEDICAID/ STATE AID _____ EMSA TOTAL CARE _____

INSURANCE CARRIER: _____ POLICY #: _____
MEDICAID # OR SSI #: _____ TOTAL CARE #: _____

STUDENT'S PRIMARY CARE PHYSICIAN: _____ HOSPITAL PREFERENCE: _____

STUDENT'S ALLERGIES: _____ NONE KNOWN: _____

MEDICAL CONDITION/PAST MEDICAL HISTORY: _____
_____

CURRENT MEDICATIONS & DOSAGES: _____

_____

FOR THE SCHOOL NURSE/OFFICE STAFF

Today's Date: _____

PLEASE NOTE THE PRESENTING PROBLEM OR REPORTED REASON WHICH LED TO CALLING FOR AN AMBULANCE. FOR MEDICAL PROBLEMS, LIST THE SIGNS & SYMPTOMS AND THE TIME OF ONSET. FOR INJURIES, DESCRIBE THE EVENTS PRECEDING THE INJURY, AND ANY WOUNDS OR SIGNS NOTED. IF VITAL SIGNS ARE AVAILABLE, PLEASE INCLUDE THEM HERE WITH THE TIME TAKEN.
THANK YOU!

_____
_____
_____

(over)

TULSA PUBLIC SCHOOLS
Departmento de Servicios de Salud

TRANSPORTE POR AMBULANCIA
INFORMACIÓN MEDICA PARA EMERGENCIA Y
AUTORIZACIÓN PARA PROVEER TRATAMIENTO Y PARA TRANSPORTAR AL EMPLEADO

SE PIDE ESTA INFORMACIÓN PARA AYUDAR AL PERSONAL DE AMBULANCIA EN PROVEER CUIDADO AL EMPLEADO NOMBRADO. ESTA INFORMACIÓN SERA PROVEIDA SOLAMENTE A INDIVIDUOS QUE PROVEEN CUIDADO MEDICO.

NOMBRE Y APELLIDO DEL EMPLEADO: _____ FECHA DE NACIMIENTO: _____
DIRECCIÓN/CIUDAD/CODIGO POSTAL: _____
NUMERO DE TELEFONO: _____ NUMERO DE SEGURO SOCIAL: _____

PERSONA CON QUIEN COMUNICARSE EN CASO DE EMERGENCIA: _____
RELACION: _____
TELEFONO DE DIA PARA COMUNICARSE EN CASO DE EMERGENCIA: _____

PROTECCIÓN MEDICA (INDIQUE LO APLICABLE):
(Note: Esto NO afecta cuidado medico que se necesita)

NADA _____ SEGURO PRIVADO _____ MEDICAID/ AYUDA ESTATAL _____ EMSA TOTAL CARE _____

NOMBRE DEL SEGURO: _____ NUMERO DE POLIZA: _____
DE MEDICAID O DE SEGURO SOCIAL: _____ # DE CUIDADO TOTAL: _____

MEDICO PRINCIPAL: _____ HOSPITAL PREFERENCIA: _____

ALERGIAS: _____ NINGUNA CONOCIDA: _____

CONDICION MEDICA/HISTORIA MEDICA: _____
_____

MEDICINAS Y LAS DOSIS: _____
_____

PARA LA ENFERMERA DE LA ESCUELA/EMPLEADOS DE OFICINA

FECHA DE HOY: _____

FAVOR DE ANOTAR EL PROBLEMA PRESENTE O RAZON POR HABER LLAMADO UNA AMBULANCIA. PARA PROBLEMAS MEDICOS, FAVOR DE INDICAR LOS SINTOMAS Y LA HORA QUE EMPEZARON. PARA LESIONES, DESCRIBA LOS SUCESOS ANTES DEL ACCIDENTE, CUALQUIER LESIONES O DAÑOS NOTADOS. SI SEÑALES VITALES ESTA DISPONIBLES, FAVOR DE INCLUIRLOS Y LA HORA QUE FUERON TOMADOS.

GRACIAS!

_____
_____
_____

(VEA UD. EL OTRO LADO DE LA HOJA)

INFORMACIÓN MEDICA PARA EMERGENCIA Y AUTORIZACIÓN PARA DAR TRATAMIENTO Y PARA TRANSPORTAR AL EMPLEADO

AUTORIZACIÓN PARA CUIDADO DE EMERGENCIA DEL EMPLEADO

Yo doy autorización para transporter por servicio de ambulancia, con licencia del Estado de Oklahoma; y autorizo examinación de rayo x, diagnosis anestésica, dental, médica o diagnosis quirúrgica o tratamiento por cualquier medico o dentista con licencia del Estado de Oklahoma y servicio de hospital que puede estar proveído a mí bajo el permiso general, o especifico de unmiembro designado de la facultad o de la enfermera de la escuela, sin importer si taldiagnosis o tratamiento está proveido en la oficina del medico o dentista, o en un hospital licenciado por el Estado de Oklahoma. Además autorizo que dicho medico use su discreción autorizando disposición de tejido o miembro separado.

Está entendido que este permiso está dado de ante mano de cualquier diagnosis especifica o antes de cualquier tratamiento, pero está dado para animar a las personas nombradas arriba y dicho medico o dentista para que usen su major juicio en cuanto a los requisitos de tal diagnosis o tratamiento dental o quirúrgico.

Este permiso quedará en efecto hasta _____am/pm del dia _____ de _____, 20___, a lo menos que esté renunciado en forma escrita y entretado a dicho medico o dentista o dicha persona encargada con el cuidado y control dce tal hijo menor.

_____ _____

Firma del Empleado Fecha

_____ _____

Testigo (No las Personas Identificadas Arriba) Fecha

*Hay que repasar v renovar esta forma cada año escolar.

HD 38C1 (S) 08/94, 10/06, 01/07