Immunizations

Indiana State Law requires that all students be properly immunized for the health and safety of all students. You must provide the school with a complete and up to date copy of all of the required immunizations. The copy must be documented by your health care provider, health department where the child received the immunizations, or must be from an official copy of the official immunization record from the child's previous school. A complete and up to date copy of all of the above listed immunizations for your students' grade level must be provided within the first 20 days of school. The record must include ALL of the following immunizations:

Grade							
Kindergarten – 3rd Grade	5 DTap	3 Hepatitis B	4 Polio	2 Varicella	2 MMR	*2 Hepatitis A	
6th Grade	5 DTap	3 Hepatitis B	4 Polio	2 Varicella	2 MMR	*1 Tdap	*1 MCV
12th Grade	5 DTap	3 Hepatitis B	4 Polio	2 Varicella	2 MMR	1 Tdap	*2 MCV

***The highlighted vaccines indicate those that students are due for at that grade level.**

Consent to enter Immunizations into C.H.I.R.P.

I, ______________________________ (Parent/Guardian's Printed Name), give Career/Success Academy , permission to put the following information concerning my student, ______________________________ (Students Printed Name), into the Indiana State Department of Health's Children and Hoosiers Immunization Registry Program (CHIRP):

- ✓ NAME
- ✓ DATE OF BIRTH
- ✓ IMMUNIZATIONS RECEIVED AND THE DATES THEY WERE ACQUIRED
- ✓ PARENT/GUARDIANS FIRST NAME

I understand that the information in the registry may be used to verify that my student has received proper immunizations and to inform me or my student of his/her immunization status or that an immunization is due according to recommended immunization schedules.

I understand that my student's information may be available to the immunization data registry of another state, a healthcare provider or a provider's designee, a local health department, an elementary or secondary school, a child care center, the office of Medicaid policy and planning or a contractor of the office of Medicaid policy and planning, a licensed child placing agency, and a college or university. I also understand that other entities may be added to this list through amendment to I.C. 16-38-5-3.

I hereby consent to the release of such information.

______________________________ ______________
Printed Name of Parent/ Guardian *Date*

____
Signature of Parent/Guardian

____
Child's Printed Name

Career/Success Academy ______________
School *Grade*

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Student

Health

Services

Student Emergency, Health and Medication Form

Students' grade level for this year:	(circle one) K 1 2 3 4 5 6 7 8 9 10 11 12
Students' Name:	Students' Date of Birth:
Address:	Home Phone:
Parent/Guardian:	**Cell:**
	Work:
Parent/Guardian:	**Cell:**
	Work:

Medical History

Does this student have any of the following conditions: (Check all that apply)

- ☐ Asthma
- ☐ Seizures
- ☐ Diabetes
- ☐ Migraines
- ☐ Anxiety
- ☐ Heart Condition
- ☐ Hearing Loss
- ☐ Vision Problems

Please describe any conditions I need to be aware of to care for your child:
____
____
____

Does this student have a food, latex, or other Allergy? ☐ Yes ☐ No If yes, list ______________________________

Has this student ever had chicken pox? ☐ Yes ☐ No If yes, when? ____________________________________

Daily Home Medications:
Daily School Medications:

In case of serious illness or injury where immediate care is needed, the school or its representative has my permission to contact the appropriate emergency medical service. The emergency medical service has my consent to provide necessary treatment or transportation for my child. I then request that I be notified of the situation. The undersigned will be responsible for emergency treatment cost. In the case of an accident or illness where immediate treatment of my child is not indicated, but where he or she is unable to remain at school, I request that the school contact me or my designee to arrange transportation for my child. If the school is unable to contact me, I request that one of the other persons listed on this card be contacted and requested to care for my child. In the event no person designated on this care is available, emergency medical services may be contacted for further assessment and possible transport and treatment. I understand that certain educational records of my child will be shared with Success/Career Academy healthcare partners as needed to provide and evaluate health services to students. I also understand and agree that my child's medical treatment records created by SA/CA healthcare personnel at SA/CA may be shared with school officials who have a legitimate educational purpose for accessing such records.

Parent/Guardian signature: ________________________________ ____________
Signature of Parent/Guardian Date

CONSENT FOR OVER-THE-COUNTER MEDICATIONS TO BE GIVEN AT SCHOOL
(Only valid if Parent/Guardian checks off and signs below)

I give permission for ______________________________________ to receive the following medication:
(Student's Name)

Tylenol or Ibuprofen, dose per weight, every 6 hours as needed for minor pain. ☐ YES ☐ NO
Please notify me when my child takes Acetaminophen at school: ☐ YES ☐ NO

Antacid (Tums), 420mg tab, chewed, every 2 hours as needed for acid indigestion. ☐ YES ☐ NO
Please notify me when my child takes Antacid at school. ☐ YES ☐ NO

Cough Drops, 1 every 2 hours as needed for cough/minor throat irritation. ☐ YES ☐ NO
Please notify me when my child takes Cough Drops at school: ☐ YES ☐ NO

Parent/Guardian signature: ________________________________ ____________
Signature of Parent/Guardian Date

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