Kha'p'o Community School
625 Kee Street
Espanola, NM 87532
(505)753-4406

2020/2021 SY Health Packet

Dear Parents/Guardians,

At Kha'p'o Community School, students are fortunate to have a School Health Office that provides them care when they get sick, injured, or for any other health issue. To ensure that the students are provided the best care here at KCS, we do require the School Health Packet to be completed by the parent(s) or legal guardian(s).

Immunization requirements need to be met for your child(ren) to begin their first day of school. KCS requires students receive the following immunizations:

- **DTP/DTap/TD (tetanus, diphtheria, pertussis) vaccine**
  The new rule states that a booster dose of tetanus, diphtheria, pertussis (Tdap) is required for all students attending school. One dose required on/after 4th birthday. 4 doses sufficient if the last dose given on or after 4th birthday. This change was made to help reduce the incidence of whooping cough (pertussis) among children. In recent years, New Mexico, as well as the rest of the United States, has seen an increase in the number of whooping cough cases. By giving your children a booster of Tdap, they will receive protection against this deadly disease for the years to come. So if it has been five years since your child received a tetanus-containing vaccine, he/she will need a dose of Tdap.
- **Varicella vaccine**
  K-2nd grade, Proof of Immunity is receipt of vaccine, titer or laboratory-confirmed diagnosis of prior disease. For all newly diagnosed Varicella cases, laboratory confirmation of disease is required. 2 doses of varicella vaccine required for all students K-10th, and recommended for all students grades 11th-12th.
- **Polio (OPV/IPV) vaccine**
  3 doses are sufficient if last dose was given on or after 4th birthday.
- **Hepatitis B vaccine**
  Two doses Adult Recombivax HB is also valid if administered at ages 11-15 years and if 2nd dose received no sooner than 16 weeks after 1st dose.

As you are completing the forms, please make sure you

- Sign and date each form
- Check front and back of each form
- Submit copy of immunization (Required to be submitted at the beginning of each school year)
- Doctor's note must be submitted for ALL allergies: food, insects, medication, etc (Required to be submitted at the beginning of each school year)
- Note: Doctor's Dietary Documentation is required for Food Allergies for the Kitchen Staff to order special milk or food.
- If applicable, submit medical history (allergy, medication, restrictions, etc.) (Required to be submitted at the beginning of each school year)

Kha'p'o Community School
2020/2021 HEALTH PERMIT

Child's Name: _____ DOB: _____ Grade: _____
Mailing Address: _____ City: _____ State: ____ Zip: _____
Clinic Chart #: _____
Doctor/Pediatrician: _____ Phone #: _____
Mailing Address: _____ City: _____ State: ____ Zip: _____
Medical Insurance: _____
Who is the child living with? _____ Relation: _____
Who is the legal guardian? _____
Name other children attending KCS? _____
Is the child's immunization up to date? Yes ___ No ___ (Required Immunization Record to be submitted to KCS every school year)

Father's Name: _____ Home/Cell Phone #: _____
Home Location: _____ Email: _____
Employer: _____ Work Phone #: _____

Mother's Name: _____ Home/Cell Phone #: _____
Home Location: _____ Email: _____
Employer: _____ Work Phone #: _____

Legal Guardian's Name: _____ Home/Cell Phone #: _____
Home Location: _____ Email: _____
Employer: _____ Work Phone #: _____

EMERGENCY CONTACTS
(if we cannot reach you)

Name: _____ Home Phone #: _____
Cell Phone #: _____ Work Phone #: _____ Home Location: _____

Name: _____ Home Phone #: _____
Cell Phone #: _____ Work Phone #: _____ Home Location: _____

In case of EMERGENCIES which require medical attention during school hours, I give permission for my child to be transported for the rendering of such Medical Services as deemed necessary in the opinion of School Health Personnel.

Parent/Guardian printed name: _____ Signature: _____
Date: _____ Relationship to student: _____

HEALTH CONDITIONS (Check any your child has had and put approx. date)

Yes	Date:	No	Condition	Yes	Date:	No	Condition
			Anemia				Hepatitis
			Asthma				Kidney Disease
			Chicken Pox				Measles
			Diabetes				Mumps
			Ear infection				Seizures
			Tubes in Ears				Tuberculosis
			Hearing Problems				Vision Problems
			Heart Condition				Glasses
			Other				Other

ALLERGIES: ***Is your child allergic to any of the following?***

Medication/Drugs: Yes _____ No _____ Which ones? _____
Bee/Wasp Stings: Yes _____ No _____ EpiPen Prescribed: Yes _____ No _____
Lactose Intolerant: Yes _____ No _____ If yes, medical documentation from the doctor must be provided, every new school year.
Food/Plants/Other: Yes _____ No _____ Which ones? _____
EpiPen Prescribed: Yes _____ No _____
(Doctor's note must be provided to KCS indicating specific type of food allergies every new school year)

MEDICATIONS:

Is your child taking any medication? Yes _____ No _____
If yes, why? _____ What medication? _____
EpiPen: Yes _____ No _____ If yes, EpiPen must be provided to the school. (No expired medication will be accepted)
Inhaler: Yes _____ No _____ What type of inhaler? _____ If yes, inhalers must be provided to the school. (No expired medication will be accepted)
Date of last eye exam: _____ Where: _____
Does your child wear eyeglasses? Yes _____ No _____ Date of eyeglass prescription: _____
Is your child's eye glass prescription current? Yes _____ No _____

All over the counter (OTC) and prescription medication sent to school must be in the same prescription/OTC container as put up by the pharmacist/store and must have the patient's NAME, NAME OF MEDICATION, DOSAGE, AND DIRECTIONS on the label. A 2020/2021 parent authorization to receive OTC/RX medication at school must be completed and signed. Medication will be sent to the School Health Office. The School Health Office will give your child the medication.

I give permission for my child to receive the **OVER the COUNTER** medicine I checked below for relief of discomfort due to minor accident or illness. Please check all that apply for your child.

Acetaminophen (Tylenol)		Sudafed		Hydrocortisone 1%	
Ibuprofen/Motrin		Head lice Treatment		Bacitracin Ointment	
Cold Medicine		Pepto-Bismol		Cough Medicine	
Benadryl		First Aid Cream		Burn Gel/Spray	
Calamine Lotion		Eye Drops			

Parent/Guardian printed name: _____ Signature: _____
Date: _____ Relationship to student: _____

Kha'p'o Community School
2020/2021 Parent Authorization to Receive Over The Counter/Prescrption Medication at School

Date: _____ Authorization Expires: _____

Child's Name: _____ DOB: _____
Teacher: _____ Grade: _____

Name of Medication(s): _____
_____
_____
Doctor/NP/PA: _____
Office/Clinic Name: _____ Phone #: _____
What time should medicine be given? _____
Any special instructions? _____

**Medicine needs to be in the original bottle with the over the counter or pharmacy label or original packaging. The school Health Office will document all medication administered. They will NOT give medicine that is expired, or out of its original bottle. They will not give medication without this consent. **

Parent/Guardian Consent: I request the School Health Office to administer my child's medication as described above. I release Kha'p'o Community School and its staff members from liability regarding administration of this medication.

Parent/Guardian printed name: _____ Signature: _____
Date: _____ Relationship to student: _____