New Student Enrollment Application

2019-2020

First Mesa Elementary School

Student Name: _____ Grade: _____

Cover Page/Check List

____ Student Application (2 Pages)

____ Student Check Out Form (1 Page)

____ Student Transportation Form (1 Page)

____ Student Health History (1 page)

____ Medical Attention Form (1 Page)

____ OTC Medication Consent Form (1 Page)

____ One Call Now Form (1 page)

____ FERPA Form (1 page)

____ Student Residency Verification Document (1 Page)

____ 2019-2020 Influenza Vaccination Consent Form (1 page)

____ Annual Participation Physical Exam Form (2 pages)

____ Release of Records Form (1 page)

____Sports/Local Field Trip/Photo Consent Form (1 page)

***Required documentation at time of registration:**

____ ***Birth Certificate** ____***Tribal Enrollment/CIB** ____ ***Updated Immunization Records**

____ ***Affidavit of Temporary Guardianship (if applicable)**

NOTE: INCOMPLETE APPLICATIONS WILL DELAY STUDENT ENROLLMENT. PLEASE ENSURE TO HAVE ALL PROPER DOCUMENTATION AT TIME OF ENROLLMENT.

FOR OFFICAL USE ONLY

Received Date: _____ Received by: _____

Status: COMPELTE_____ PENDING____

Comments: _____

Enrollment: APPROVED_____ DISAPPROVED_____

Principal's Signature: _____ Date: _____

NASIS Entry Date: ___/____/____ Enrollment Code: _____ NASIS ID#_____

Teacher Placement: _____ Grade: _____ Room #_____

First Mesa Elementary School
P.O. Box 750
Polacca, AZ 86042
Phone: 928-737-2581 Fax: 928-737-2323

New Student Enrollment Application

IDENTIFICATION:

Student Name: (Last, First, MI)	Grade:
Gender: Male( ) Female ( )	Date of Birth:
Place of Birth:	Age:

ADDRESS:

Mailing Address: (PO Box #, City, Zip Code)	Physical Address: (Directions/Description of home, City, Zip Code)

ETHNICITY (Please choose one of the following Federally Mandated Categories):

( ) American Indian or Alaskan Native	( ) Native Hawaiian or Other Pacific Islander
Tribal Affiliation:	( ) Asian
Village Affiliations:	( ) Caucasian/White
Enrollment/CIB #:	( ) African American/Black

FAMILY DATA INFORMATION:

	Last/First Name, Address	(x) lives with student	(x) has legal custody	Home Phone/Cell Phone	Employer/ Work Phone	Email Address
Father						
Mother						
Step-father						
Step-mother						
Other (specify)						

Note: In cases where custody/visitation affects the school, the school shall follow the most recent court order on file with the school. It is the responsibility of the custodial parent/guardian to provide the school with the most current court order.

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FAMILY DATA (CONT.) please list brothers/sisters of student now living in home:

Name:	Age:	School Attending:
1.		
2.		
3.		

PREVIOUS SCHOOL INFORMATION:

Last School Attended:	School Address:	Grade:	Date Withdrawn:
Has student ever attended First Mesa Elementary? ( ) Yes ( ) No	Has student ever been retained: ( ) Yes ( ) No	If "Yes", what grade:	Other Schools Attended:

SPECIAL SERVICES (Please check all that apply) Note: If "X" please provide most recent information, i.e. IEP, etc.

Special Education		Speech Therapy	
Physical Therapy		Gifted & Talented	
Occupational Therapy		Completed Head Start	
Counseling		Section 504 Plan	

EMERGENCY CONTACT INFO (please list individuals other than yourself to be contacted):
Note: Parents/Guardians will be the 1st point of contact. If parent/guardian is unavailable, listed individuals will be contacted.

Name:	Relationship to student:	Home Phone #	Cell Phone #	Work Phone #

I/We (Parent/Guardian) am/are legally responsible for this student and hereby apply for his/her admission to First Mesa Elementary School. I/we understand that additional information may be requested by the school before the student is enrolled.

Signature of Parent/Guardian: _____ Date: _____
Signature of Parent/Guardian: _____ Date: _____

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Student Name: _____ Grade: _____

Student Check Out Form

Parents or legal guardians of students must designate authorized individuals to check out his/her student. Phone calls will not be accepted for check out authorization.

NOTE: A person checking out a student must be prepared to show proper identification.

Please list each individual below **(including yourself)**.

Individual Name:	Relationship:	Contact Phone #:

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

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New Student Enrollment Application

Student Name: _____ Grade: _____

Student Transportation Form

PARENT/GUARDIAN CONTACT INFORMATION

Parent/Guardian Name	Relationship	Home Phone	Cell Phone

Village/Community: _____

Primary AM Pick Up Location	**Primary PM Drop Off Location**	**Alternative PU/DO Location**
MAP	**MAP**	**MAP**

Special Needs Accommodations required? YES ( ) NO ( )
Please list accommodations needed: _____

- Pick -Up and Drop -Off destinations are scheduled as close as possible to student's residence. If roads become impassable (i.e. muddy roads, etc.) due to inclement weather or other reasons, buses will not transport on dirt roads. Parents are encouraged to use alternative stops.
- Students are encouraged to utilize primary arrangements. This eliminates overcrowding on buses.
- Alternate Pick up and Drop Off arrangements are encouraged to be communicated in advance. **Only a Parent/Guardian written note will be accepted. NO Phone Call Arrangements.**
  - On Full Days, bus notes will be accepted until 12:00 PM.
  - On Half Days, bus notes will be accepted until 10:00 AM.
  - Emergencies and urgent changes after the listed times or arrangements without a written note must be approved by the Registrar.
- Kindergarten students must be received at their PM Drop Off.

Parent/Guardian Signature: _____ Date: _____
Parent/Guardian Signature: _____ Date: _____

For Official Use Only:

Bus Driver Assignment: _____ Bus #_____

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New Student Enrollment Application

Student Name: _____ Grade: _____

Student Health History

Gender: Male( ) Female ( )	Date of Birth:	Age:
Parent(s)/Guardian(s) Name:	Address:	Physical Address:
Home Phone:	Cell Phone:	Work Phone:

HEALTH HISTORY:

Please check "YES" OR "NO" for the following health conditions. If "YES", please indicate the age of diagnosis.

Condition	YES	NO	AGE	Condition	YES	NO	AGE
Anemia				Hepatitis			
Arthritis				Tuberculosis			
Asthma				Kidney Problems			
Allergies (i.e. food, seasonal, medication, etc.)				Migraine Headaches			
Back Problems				Seizures/Epilepsy			
Behavioral Health: (anxiety, depression, anger issues, etc.)				Spinal Injuries			
Diabetes				Sore Throats			
Wears Glasses/Contacts				Surgeries or Operations			
Hyperactive				Sprains or Fractures			

If "YES" to any of the above, please explain briefly: _____

_____

_____

_____

Is your child currently taking prescribed medications or over the counter medication? YES ( ) NO ( )

If "YES", when does medication to be administered? ( ) During School Hours ( ) At Home

If "YES", please complete the following sections:

Type of Medication:	Diagnosis/Reason for Medication:
Time(s) Medication is Administered:	Dates Medication is Administer: From: To:
Hospital Name & Address:	Physician's Name & Phone Number:

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

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Student Name: _____ Grade: _____

Medical Attention Form

First Mesa Elementary School provides a health care program for all students. Clinical care will be provided during the present clinic hours by qualified and authorized medical personnel in the nurse's office. Parents/Guardians must take student to the hospital/clinic for care during times when the nurse's office is closed.

The Nurse's Office at First Mesa Elementary School agrees to provide the following services:

- Emergency Medical Care: for accidents or serious illness occurring during school hours. When necessary, the student will be transported to the Hopi Health Care Center.
- Routine Health Care includes: preventative health screening and health counseling. Available services may include: immunizations, care for adolescent physical concerns, drug and alcohol assessment, counseling, and dental care including sealants and preventative use of fluorides.
- Care for Non-Emergency Illnesses includes: topical antibiotics and indicated medical prescriptions.
- Immunizations: State Law requires that ALL school age children MUST have current immunization records on file in order to be enrolled and attend school. Please bring your child's most recent immunization record with you during enrollment process. (Please refer to the Arizona School Immunization Law for more information.)
- Vision, Hearing, and Scoliosis Screening: of select students in accordance with state regulations, and any student requesting examinations.
- Behavioral Health Services: including evaluation and treatment as necessary. In the event of a behavior issues where a child may cause harm to self to others, the following steps may be taken:
    - Parent/Guardian will be notified.
    - The Hopi Emergency Medical Services (EMS) will be contacted.
    - The Hopi Law Enforcement Services (HRES or BIA Police) will be contacted.
    - School Personnel may exercise reasonable care to ensure the safety of the student and others.

All medical records are kept confidential. No medical information will be shared between staff and school personnel unless important to student care. No elective procedures will be performed without parental permission. Student will be guaranteed confidential care in accordance with Arizona State Law.

( ) I (We) hereby consent for all the services listed above.
( ) Exceptional or Special Instructions: _____
_____
_____

I (we) fully understand all statements/guidelines of provided medical services available to my child while attending First Mesa Elementary School.

Parent/Guardian Signature: _____ Date: _____
Parent/Guardian Signature: _____ Date: _____

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Student Name: _____ **Grade:** _____

Permission to Administer OTC Medications at School

First Mesa Elementary School has common "over the counter "(OTC), medications in our Nurse's Office. We use brand names and generic name medicines. If you would like FMES to offer your child these medicines, please ***CIRCLE*** **"Yes"** or **"No"** for the following OTC medications listed below.

Yes	No	**Aloe Vera Gel** – (Burns)
Yes	No	**Advil / Ibuprofen** – (Injury, pain, and swelling)
Yes	No	**Bacitracin Zinc Ointment / Neosporin** – (Anti-infection ointment)
Yes	No	**Benadryl / Diphenhydramine** – (Oral medication given for suspected allergic reactions and seasonal allergy symptoms, may cause drowsiness. Medication will ONLY be administered to students after consulting with parents. ***Cream/Ointment*** is used for itchy insect bites or rash.)
Yes	No	**Tylenol / Acetaminophen** – (Fever, Pain).
Yes	No	**Claritin / Loratidine** – (Oral medication given for suspected allergic reactions and seasonal allergy symptoms, does not induce sleep. Medication will ONLY be administered to students after consulting with parents.
Yes	No	**Chloraseptic Spray** – (Sore throat, numbing sensation).
Yes	No	**Cortisone Cream / Anti-itch cream** – (Insect bites, itching and inflammation of skin).
Yes	No	**Menthol Cough Drops** – (Cough)
Yes	No	**Pepto Bismal / Bismuth Subsalicylate** – (Diarrhea, nausea, and upset stomach).
Yes	No	**Tums / Calcium Carbonate** – (Stomach ache, heartburn).

NOTE: Please notify the nurse what other medications your child takes at home.

I have circled "Yes" for medicines my student may be given at school and have circled "No" for medicines that should NOT be given to my child.

Parent/Guardian Signature: _____ **Date:** _____

For Official Use ONLY

Received by Nurse/Staff On: _____ Signature: _____

Updated 05/29/2019 EM

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New Student Enrollment Application

Student Name: _____ Grade: _____

Sports Participation/Local Field Trip/Photo Consent

First Mesa Elementary School (FMES) offers participating in sports offered by the Hopi Elementary Athletic League (HEAL). Students who will participate in any sports activity must have a completed Annual Participation Physical Examination on file prior to participation. Physicals are good for one (1) school year.

FMES provides extracurricular activities and involvement in school clubs. During the school year, local trips sponsored by a school organization (i.e. Student Council, 6th Grade transition, Gifted and Talented, etc.) may be planned. Parents/Guardians will be given prior notification of any trips off campus.

FMES may at times take photographs of school sponsored events. Such photos may depict students' name, class or group involvement and may only be used for publicity, illustration, advertising and web content. Only with parental consent will photographs be utilized for such use.

Please initial those that apply:

_____ I (we) hereby grant permission for my/our child to participate in the HEAL Sports program which includes but is not limited to, cross country, basketball and cheerleading. I (we) understand that my/our child will need a current Annual Participation Physical Examination on file prior to participation.

_____ I (we) hereby grant permission for my/our child to participate in the organized school sponsored activity trip as approved. I (we) understand that students will be properly chaperoned and all precautions will be taken to ensure his/her safety.

_____ I (we) grant to First Mesa Elementary School (FMES), its representative and employees the right to take photographs of my child in connection with school wide activities for the current school year. I authorize FMES, it assignees and transferees to copyright, use and publish the same in print and/or electronically. I (we) agree that FMES may use such photographs of my child with or with his/her name and for any lawful purpose, including publicity, illustration, advertising and web content.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

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ONE CALL SYSTEM

One Form Per Household

First Mesa Elementary School uses the "One Call" System to better our communication with Parents/Guardians. Messages are sent via phone, email and/or text. These messages will include weekly activities, emergencies, delays, etc. Please indicate your information below if you would like to be part of this communication system.

Student Name:	Grade:
Student Name:	Grade:
Student Name:	Grade:
Student Name:	Grade:
Student Name:	Grade:
Student Name:	Grade:

Please check all that will apply:

	CELL PHONE	#:	Name:
	CELL PHONE	#:	Name:
	HOME PHONE	#:	Name:
	HOME PHONE	#:	Name:
	EMAIL		Name:
	EMAIL		Name:

Parent/Guardian Name: _____ Date:_____

Parent/Guardian Signature: _____ Date: _____

Official Use ONLY

Data Entry Date: _____ Signature One Call Administrator: _____

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New Student Enrollment Application

Family Educational Rights and Privacy Act (FERPA)
School Year 2019-2020

I have received information about my rights under FERPA and understand my right to request that any of the items listed below not be disclosed as Directory Information to any outside group, other than those having a legal right to the information, without my written permission. Those having a legal right might include federal auditors, those having oversight responsibilities, circumstances regarding health and safety, emergencies or other similar entities.

Student Name: _____ Grade: _____

[ ] I **allow** the following directory information regarding my student to be disclosed:
Check all that apply:

1. [ ] Student's name
2. [ ] Participation in officially recognized activities and sports
3. [ ] Telephone listing
4. [ ] Age of members of athletic teams
5. [ ] Photograph
6. [ ] Honors and awards received
7. [ ] Dates of attendance
8. [ ] Grade level

[ ] I do **NOT** want any directory information regarding my student disclosed. (No information will be disclosed without prior written permission).

Parent/Guardian Name (PRINT):_____

Parent/Guardian Signature: _____ Date:_____

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New Student Enrollment Application

Student Residency Verification Document

Student Name	Grade	Date of Birth

The purpose of this form is to address the requirements of the McKinney – Vento Act. This document will be used by school personnel and partnering agencies to ensure all providers have the necessary information to support the child and his/her family.

1. Presently, where is the student living? Check one box

SECTION A	SECTION B
□ in a shelter □ with more than one family in a house or apartment □ in a motel, car or campsite □ with friends or family members (other than parent/guardians) **CONTINUE:** If you have checked a box in Section A, complete # 2 and the remainder of this form.	□ Choices in Section A do not apply **STOP**: If you have checked this Section, you do NOT need to complete the remainder of this form. Please submit to school personnel.

2. Does the student live with:
   - □ One (1) Parent
   - □ Two (2) Parents
   - □ One (1) Parent and another adult
   - □ A Relative, Friend(s), or other adult
   - □ Alone with no Adults
   - □ An adult that is not the parent or legal guardian

Name of Parent(s)/Legal Guardian: PLEASE PRINT	
Mailing Address, State, Zip Code	
Phone Number:	
Signature of Parent/Legal Guardian:	

For Official Use Only:

If the parent has checked Section B above, completion of this form is not required.
For any choices in Section A, this form must be completed and provided to School Registrar immediately after completion. Form will be kept separately from the Student Cumulative Record for audit proposes during the school year.

School Administrator's determination of Section A circumstances:	
School Contact Person who may know of the family's situation & Phone #:	
Date Faxed to the Office of Coordinator:	

Updated 05/29/2019 EM

First Mesa Elementary School
P.O. Box 750
Polacca, AZ 86042
Phone: 928-737-2581 /737-0133 Fax: 928-737-2323
"Building a Ladder to Success"

Primary Home Language Survey

Complete survey and return to Enrollment Office upon student registration. Responses to these statements will be used to determine whether the student will be assessed for English Language Proficiency.

Survey questions are in compliance with Arizona Administrative Code, R7-2-306(B)(1), (2)(a-c).

1. What is the primary language used in the home regardless of the language spoken by the student? _____
2. What is the language most often spoken by the student? _____
3. What is the language that the student first acquired? _____

Student Name: _____ Grade:_____

Date of Birth: ____/_____/_____

Parent/Guardian Name: (**Please Print**)_____

Parent/Guardian Signature: _____ Date:_____

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Release of Records

Office of Registrar

Student Name	Date of Birth	Grade

The above named student has recently enrolled at First Mesa Elementary School. To ensure proper placement and services, please forward this student's academic and health records, including but not limited to, the following:

Academic & Attendance Records	Special Education Records (IEP & 504 Plans)
Health & Immunization Records	Related Services Records i.e. Speech, OT/PT, etc.
Official Transcripts/Report Cards	Psychological Evaluation Records
Achievement Test Scores (AZ Merit/Stanford/etc.)	Gifted and Talented Records
Discipline Records	Birth Certificate
Official Withdrawal Forms	Tribal Enrollment/CIB

Record Released From (Previous School Name):	
Title/Department:	
Address:	
City/State/Zip:	
Phone Number:	
Fax Number:	

It is understood that the confidentiality of such records continue to be maintained. Thank you for your assistance and prompt attention to this request.

Parent/Guardian Signature: _____ Date: _____

Name/Title of School Official: _____ Date: _____

Signature of School Official: _____ Date: _____

NOTE: According to the Education Amendments of 1974, "Protection of the Rights and Privacy of Parents and Students," Section 438, Subsection (B) (1), Parts A& B, Page 97; School Officials, including teachers with the educational institution and office of other school in school systems in which the student may intend to enroll, may receive a student's record without a written consent for such release. Also pursuant to State Law 15-828, Paragraph F; no school shall withhold records due to financial debts.

For Official Use Only

1st Request	2nd Request	3rd Request

"Building a Ladder to Success"

Updated 9.13.2016 DN

First Mesa Elementary School
P.O. Box 750
Polacca, AZ 86042
Telephone: 928-737-2581
Fax: 928-737-2323

"Committed To Education Excellence"

Name_____ Sex_____ Age_____ Date of Birth_____ Grade_____

Address_____ Phone_____

In case of emergency, contact: Name_____

Explain "yes" answers below. Phone(H)_____ (W)_____

Circle questions you don't know the answer to. Cell Phone:_____

	Yes	No
1. Have you had a medical illness or injury since your last check-up or sports physical? Do you have an ongoing or chronic illness? Are you currently being treated for an injury or condition?		
2. Have you ever been hospitalized overnight? Have you ever had surgery?		
3. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler?		
Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?		
4. Do you have any allergies to medications? _____ Do you have any allergies to pollen, food or stinging insects?		
Have you ever had a rash or hives develop during or after exercise?		
5. Have you ever passed out during or after exercise? Have you been dizzy during or after exercise? Have you ever had chest pain during or after exercise? Do you get tired more quickly than your friends during exercise? Have you ever had racing of your heart or skipped heartbeats? Have you had high blood pressure or high cholesterol? Have you ever been told you have a heart murmur? Have you had a severe viral infection (i.e., mononucleosis or myocarditis) within the last month? Has a doctor ever denied or restricted your participation in sports for any heart problems? Has anyone in your immediate family had the following conditions? Diabetes____Heart disease____other____ Sudden death prior to age 50____High Blood Pressure____		
6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?		
7. Have you ever had a head injury or concussion? Have you ever been knocked out, become unconscious, or lost your memory? Have you ever had a seizure? Do you have frequent or severe headaches? Have you ever had numbness or tingling in your arms, hands, legs, or feet? Have you ever had a stinger, burner, or pinched nerve?		
8. Have you ever become ill from exercising in the heat?		
9. Do you cough, wheeze, or have trouble breathing during or after activity? Do you have asthma? Do you use an inhaler? Do you have seasonal allergies that require medical treatment?		
10. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)? _____		
11. Have you had any problems with your eyes or vision? Do you wear glasses, contacts, or protective eyewear?		
12. Have you ever had a sprain, strain, or swelling after injury? Have you broken or fractured any bones or dislocated any joints? Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?		

If yes, check appropriate box below.

[] Head	[] Elbow	[] Hip
[]Neck	[]Forearm	[]Thigh
[]Back	[]Wrist	[]Knee
[]Chest	[]Hand	[]Shin/calf
[]Shoulder	[]Finger	[]Ankle
[]Upper arm		[]Foot

Explanation:_____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. I understand and acknowledge that truthful and accurate information is essential in properly determination whether the student should be cleared for athletic participation

I hereby consent for the student named above, to be given medical care by the doctor selected by the school.

_____ _____ _____

Signature of Parent/Guardian Signature of Student Athlete Date

First Mesa Elementary School
P.O. Box 750
Polacca, AZ 86042
Telephone: 928-737-2581
Fax: 928-737-2323

"Committed To Education Excellence"

ANNUAL PARTICIPATION PHYSICAL EXAMINATION

ANNUAL PHYSICAL EXAMINATION

Name:_____ Date_____

Height:_____ Weight:_____ Pulse:_____ BP:_____

Vision: R20/_____ L20/_____ Glasses/Contacts: Yes[ ] No[ ] Pupils: Equal _____ Unequal_____

	Normal	Abnormal Findings	Initials*
Medical			
Appearance			
Skin			
Eyes/Ears/Nose			
Throat/Oropharynx			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia/Hernia			
Musculoskeletal			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand			
Hip/thigh			
Knee			
Leg/ankle			
Foot			

*Station-based question only

*Other studies/Evaluations/Comments (if applicable):

_____

_____

_____

Immunizations Up to Date? [ ] Yes [ ] No (Copy attached)

CLEARANCE

[ ] Cleared

[ ] Cleared after completing evaluation/rehabilitation for:_____

_____

_____

[ ] Not Cleared for:_____ Reason:_____

Recommendations:_____

_____

Name of Physician (print/type)_____ Date_____

Address_____ Phone_____

Signature of Physician_____ MD/DO/NP/PA-C

DEPARTMENT OF HEALTH & HUMAN SERVICES **Public Health Service**

Hopi Health Care Center
P.O. Box 4000
Polacca, Arizona 86042-4000

SCHOOL _____ **DATE**_____

PERMISSION TO PARTICIPATE IN THE DENTAL DISEASE PREVENTION PROGRAM

NAME OF CHILD_____(print) DATE OF BIRTH_____

GRADE_____ CLASS_____ TEACHER_____

By signing this form I give permission for my child to participate in the Hopi Health Care Center Health Promotion Disease Prevention dental services. These services are to be provided at scheduled times by HHCC dentists or dental assistants who are licensed and certified to provide The following preventive services:

1. Dental Screening- this allows the dental provider an opportunity to look inside the mouth.
2. Application of Fluoride Varnish- this allows the outside surface of the tooth to be "hardened" so that the tooth can be more resistant to cavities or decay. It is painted on with a brush.

_____ **YES, PERMISSION IS GIVEN** _____**NO, PERMISSION IS NOT GIVEN**

In order to be treated safely in the public school setting, please provide the following brief medical history for your child:

MY CHILD:

-Is currently taking the following medication(s)_____
-Has the following medical conditions(s)_____
-Has allergies to the following medication(s) OR food(s)_____
-Is currently having their dental care provided at:_____

PARENT/GUARDIAN SIGNATURE:

PRINT_____ SIGN_____ DATE_____

ADDRESS_____

PHONE NUMBER 1 _____ **PHONE NUMBER 2**_____

This program is intended to prevent dental disease. It is NOT INTENDED to take the place of regular dental check-ups or examinations performed at HHCC Dental Department OR at the private dental provider of your choice

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service
Indian Health Service

Hopi Health Care Center
P.O. Box 4000
Highway 264, MM 388
Polacca, Arizona 86042

Influenza Vaccination Clinic
2019-2020 PARENTAL CONSENT FORM

****Regular Seasonal Flu ****

Section 1: Information about Child to Receive Vaccine (please print)

STUDENT INFORMATION		
Last Name	First Name	Middle Initial
STUDENT'S DATE OF BIRTH Month: Day: Year:	HHCC Chart # Yes or No	STUDENT'S GENDER Male or Female
PARENT/LEGAL GUARDIAN		
Last Name	First Name	Middle Initial

***** If this is the FIRST time your child (8 years old and younger) is receiving the Influenza vaccine, she/he is required to return to clinic for a booster in 4 weeks. Parent(s)/guardian(s) must make this arrangement. *****

The following questions will help us know if your child can get the 2019-2020 Influenza vaccine.

Section 2: Child Health History

	YES	NO
1. Does your child have a serious allergy to eggs?		
2. Does your child have any other serious allergies that you know of? If so, please list:		
3. Has your child ever had a serious reaction to a previous dose of flu vaccine?		
4. Has your child ever had Guillian-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?		
5. Does your child have any chronic illnesses such as **asthma, seizures, heart disease**, or other **medical conditions** that require frequent doctor visits and medications? **If you indicate *YES*, your child will receive a shot.**		

Section 3: Consent for Vaccination

☐ **I GIVE CONSENT:** I have read and understand the VIS on Inactivated Influenza Vaccine.

_____ _____

Signature of Parent/Legal Guardian Date

Please return to your child's school as soon as possible.

For more information about the 2019-2020 Seasonal Influenza vaccine, please call the Hopi Health Care Center at (928) 737-6257.

VACCINE INFORMATION STATEMENT

Influenza (Flu) Vaccine (Inactivated or Recombinant): *What you need to know*

Many Vaccine Information Statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1 Why get vaccinated?

Influenza ("flu") is a contagious disease that spreads around the United States every year, usually between October and May.

Flu is caused by influenza viruses, and is spread mainly by coughing, sneezing, and close contact.

Anyone can get flu. Flu strikes suddenly and can last several days. Symptoms vary by age, but can include:

- fever/chills
- sore throat
- muscle aches
- fatigue
- cough
- headache
- runny or stuffy nose

Flu can also lead to pneumonia and blood infections, and cause diarrhea and seizures in children. If you have a medical condition, such as heart or lung disease, flu can make it worse.

Flu is more dangerous for some people. Infants and young children, people 65 years of age and older, pregnant women, and people with certain health conditions or a weakened immune system are at greatest risk.

Each year **thousands of people in the United States die from flu**, and many more are hospitalized.

Flu vaccine can:

- keep you from getting flu,
- make flu less severe if you do get it, and
- keep you from spreading flu to your family and other people.

2 Inactivated and recombinant flu vaccines

A dose of flu vaccine is recommended every flu season. Children 6 months through 8 years of age may need two doses during the same flu season. Everyone else needs only one dose each flu season.

Some inactivated flu vaccines contain a very small amount of a mercury-based preservative called thimerosal. Studies have not shown thimerosal in vaccines to be harmful, but flu vaccines that do not contain thimerosal are available.

There is no live flu virus in flu shots. **They cannot cause the flu.**

There are many flu viruses, and they are always changing. Each year a new flu vaccine is made to protect against three or four viruses that are likely to cause disease in the upcoming flu season. But even when the vaccine doesn't exactly match these viruses, it may still provide some protection.

Flu vaccine cannot prevent:

- flu that is caused by a virus not covered by the vaccine, or
- illnesses that look like flu but are not.

It takes about 2 weeks for protection to develop after vaccination, and protection lasts through the flu season.

3 Some people should not get this vaccine

Tell the person who is giving you the vaccine:

- **If you have any severe, life-threatening allergies.** If you ever had a life-threatening allergic reaction after a dose of flu vaccine, or have a severe allergy to any part of this vaccine, you may be advised not to get vaccinated. Most, but not all, types of flu vaccine contain a small amount of egg protein.
- **If you ever had Guillain-Barré Syndrome (also called GBS).** Some people with a history of GBS should not get this vaccine. This should be discussed with your doctor.
- **If you are not feeling well.** It is usually okay to get flu vaccine when you have a mild illness, but you might be asked to come back when you feel better.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

4 Risks of a vaccine reaction

With any medicine, including vaccines, there is a chance of reactions. These are usually mild and go away on their own, but serious reactions are also possible.

Most people who get a flu shot do not have any problems with it.

Minor problems following a flu shot include:

- soreness, redness, or swelling where the shot was given
- hoarseness
- sore, red or itchy eyes
- cough
- fever
- aches
- headache
- itching
- fatigue

If these problems occur, they usually begin soon after the shot and last 1 or 2 days.

More serious problems following a flu shot can include the following:

- There may be a small increased risk of Guillain-Barré Syndrome (GBS) after inactivated flu vaccine. This risk has been estimated at 1 or 2 additional cases per million people vaccinated. This is much lower than the risk of severe complications from flu, which can be prevented by flu vaccine.
- Young children who get the flu shot along with pneumococcal vaccine (PCV13) and/or DTaP vaccine at the same time might be slightly more likely to have a seizure caused by fever. Ask your doctor for more information. Tell your doctor if a child who is getting flu vaccine has ever had a seizure.

Problems that could happen after any injected vaccine:

- People sometimes faint after a medical procedure, including vaccination. Sitting or lying down for about 15 minutes can help prevent fainting, and injuries caused by a fall. Tell your doctor if you feel dizzy, or have vision changes or ringing in the ears.
- Some people get severe pain in the shoulder and have difficulty moving the arm where a shot was given. This happens very rarely.
- Any medication can cause a severe allergic reaction. Such reactions from a vaccine are very rare, estimated at about 1 in a million doses, and would happen within a few minutes to a few hours after the vaccination.

As with any medicine, there is a very remote chance of a vaccine causing a serious injury or death.

The safety of vaccines is always being monitored. For more information, visit: **www.cdc.gov/vaccinesafety/**

5 What if there is a serious reaction?

What should I look for?

- Look for anything that concerns you, such as signs of a severe allergic reaction, very high fever, or unusual behavior.

  Signs of a severe allergic reaction can include hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, and weakness. These would start a few minutes to a few hours after the vaccination.

What should I do?

- If you think it is a severe allergic reaction or other emergency that can't wait, call 9-1-1 and get the person to the nearest hospital. Otherwise, call your doctor.
- Reactions should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your doctor should file this report, or you can do it yourself through the VAERS web site at **www.vaers.hhs.gov**, or by calling **1-800-822-7967**.

VAERS does not give medical advice.

6 The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines.

Persons who believe they may have been injured by a vaccine can learn about the program and about filing a claim by calling **1-800-338-2382** or visiting the VICP website at **www.hrsa.gov/vaccinecompensation**. There is a time limit to file a claim for compensation.

7 How can I learn more?

- Ask your healthcare provider. He or she can give you the vaccine package insert or suggest other sources of information.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636 (1-800-CDC-INFO)** or
  - Visit CDC's website at **www.cdc.gov/flu**

Vaccine Information Statement

Inactivated Influenza Vaccine

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Office Use Only

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