## STUDENT NAME/Nombre \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ BIRTHDATE/Fecha de Nacimiento\_\_\_\_\_\_\_\_\_\_\_\_

**DOCTOR NAME/Nombre de su Medico\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE/Telefono\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**LIFE THREATENING MEDICAL CONDITIONS: DOES YOUR CHILD HAVE A MEDICAL CONDITION THAT WOULD PUT THEM IN DANGER OF DEATH WITHOUT A MEDICATION OR TREATMENT?**

**Condiciones Medicas que Amenazen su Vida: Tiene su nino/a un condicion medico que lo pondrian en peligro de muerte sin una medicina o tratamiento?**

**\_\_\_NO \_\_\_YES/Si IF YES, THE SCHOOL REQUIRES A MEDICATION/TREATMENT ORDER AND A MEETING WITH THE NURSE BEFORE YOUR CHILD CAN ATTEND SCHOOL.**

 **Si, Antes que su nino/a pueda asistir a la escuela, se requiere que el doctor envie las ordenas para medicinas/tratamiento y los padres necesitan hablar con la enfermera de escuela.**

**\*FORMS ARE AVAILABLE IN THE OFFICE/Los formas estan en la oficina de escuela**

**DOES YOUR CHILD HAVE ANY OF THE FOLLOWING HEALTH CONDITIONS ? \*\*\*Usually life threatening**

**Tiene su hijo/a una de los condiciones de salud siguiente?**

**\_\_\_NO \_\_\_YES/Si ALLERGY TO FOOD/Alergia a comida WHAT FOOD? Cual Comida? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_NO \_\_\_YES/Si ALLERGY TO BEE’s/Alergia a Abejas**

**\_\_\_NO \_\_\_YES/Si ALLERGY TO MEDICATION OR OTHER SPECIFY/Especifique\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_NO \_\_\_YES/Si DIABETES/Diabetes \*\*\***

**\_\_\_NO \_\_\_YES/SI SEIZURE DISORDER/Convulsion**

 **TYPE AND DATE OF LAST SEIZURE/Tipo de convulsion y fecha de la ultima:**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_NO \_\_\_YES/Si ASTHMA , REGULARLY TAKES MEDICATION FOR ASTHMA OR HAS BEEN**

 **HOSPITALIZED WITHIN THE LAST 5 YEARS FOR ASTHMA. \*\*\***

**Asma, Tome medicina con regularidad para condiciones asmaticas o ha sido hospitalizado en los ultimos 5 anos por condiciones asmaticas.**

**\_\_\_NO \_\_\_YES/Si ASTHMA, TAKES MEDICATION ONLY WHEN NEEDED**

 **Asma, Tome medicina solo cuando es necesario.**

**\_\_\_NO \_\_\_YES/Si HEART CONDITION/problemas con el Corazon**

**\_\_\_NO \_\_\_YES/Si BEHAVIORAL/EMOTIONAL CONCERN/Problemas de Comportamiento/Emocionales**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_NO \_\_\_YES/Si ORTHOPEDIC (Bone) CONDITION/problemas ortopedico (Huesos)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_NO \_\_\_YES/Si OTHER HEALTH CONDITION/Otro problemas de salud \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MEDICATIONS AT SCHOOL: STATE LAW REQUIRES WRITTEN PERMISSION FROM BOTH HEALTH CARE PROVIDER AND PARENT BEFORE ANY MEDICATION (PRESCRIPTION OR OVER THE COUNTER) CAN BE GIVEN AT SCHOOL. Medicinas: La ley del Estado requiere que la escuela reciba el permiso por escrito del doctor y los padres antes de que se le pueda administrar cualquier tipo de medicina al estudiante en la escuela. \*FORM AVAILABLE IN OFFICE/Forma en los oficinas**

**\_\_\_NO \_\_\_YES/Si DAILY MEDICINE AT SCHOOL/ Medicina diariamente en escuela**

**\_\_\_NO \_\_\_YES/Si “AS NEEDED” MEDICINE AT SCHOOL/Cuando necesita medicina durante el dia escolar**

**NAME OF MEDICATION/nombre de medicina \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DOES YOUR CHILD HAVE ANY OTHER CONDITION THAT WOULD AFFECT HIS/HER CLASSROOM PERFORMANCE OR P.E. ACTIVITIES? Tiene su nino/a algun otro problema que podrian afectar su desarrollo en el salon de clases o en las actividades de educacion fisica?**

**\_\_\_NO \_\_\_YES/Si DESCRIBE/explique si marco si \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_NO \_\_\_YES/Si GLASSES (Lentes)/CONTACTS(Lentes de contacto) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_NO \_\_\_YES/Si HEARING AIDES/Asparatos de Audicion \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

THE ABOVE INFORMATION IS CONSIDERED CONFIDENTIAL. IT WILL BE SHARED WITH SCHOOL STAFF AS NEEDED DURING THE TIME YOUR CHILD IS ENROLLED IN SUNNYSIDE SCHOOL DISTRICT IN ORDER TO ENSURE THE HEALTH AND SAFETY OF YOUR CHILD, UNLESS OTHERWISE REQUESTED BY YOU IN WRITING.

Esta informacion se considera confidencial. Sera compartida con el personal escolar solo cuando sea necesario, mientras su nino/a este inscrito en el Districto Escolar de Sunnyside, para poder asegurar la salud y seguridad de su nino/a, a menos que usted solicite lo contrario por escrito.

IN CASE OF EMERGENCY, I GIVE PERMISSION FOR SCHOOL PERSONNEL TO CALL 911 OR TRANSPORT MY CHILD TO THE DOCTOR OR HOSPITAL. En causo de emergencia, doy mi permission para el personal escolar para que llaman ala ambulancia o lleve a mi hijo/a al hospital o al medico en caso de emergency.

SIGNATURE OF PARENT/GUARDIAN Firma de Padre/Guardian DATE/Fecha

 BUS # Autobus # \_\_\_\_\_\_\_\_\_\_\_\_\_\_

TEACHER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GRADE \_\_\_\_\_\_\_\_ STUDENT ID# \_\_\_\_\_\_\_\_\_\_\_\_\_ENTRY DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_

STUDENT LAST NAME Apellido del estudiante FIRST NAME Primer Nombre MIDDLE Segundo nombre

STREET ADDRESS Domicilio CITY Ciudad MAILING ADDRESS Direccion de correo

HOME PHONE Telefono de casa BIRTHDATE Fecha de nacimiento PLACE OF BIRTH Lugar de nacimiento

LANGUAGE SPOKEN IN HOME Idioma que habla en casa FEMALE Nina MALE Nino

MOTHER’S LAST NAME FIRST NAME EMPLOYER WORK PHONE CELL PHONE

Apellido de la madre Primer nombre Lugar de trabajo Telefono del trabajo Telefono Cellular

FATHER”S LAST NAME FIRST NAME EMPLOYER WORK PHONE CELL PHONE

Apellido del padre Primer nombre Lugar de trabajo Telefono del trabajo Telefono Cellular

EMERGENCY CONTACT #1 (OTHER THAN PARENT) RELATIONSHIP Relacion PHONE Telefono

En caso de emergencia avisenle a (No los padres)

EMERGENCY CONTACT #2 (OTHER THAN PARENT) RELATIONSHIP Relacion PHONE Telefono

En caso de emergencia avisenle a (No los padres)

BABYSITTER Cuidadora STREET ADDRESS Domicilio PHONE Telefono

WHO HAS LEGAL CUSTODY? Quien tiene custodia legal? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ETHNICITY Ethnecidad HISPANIC ANGLO ASIAN AMERICAN INDIAN AFRICAN AMERICAN

IS YOUR CHILD OR HAS YOUR CHILD BEEN IN Esta o ha estado su hijo/a en:

\_\_\_\_\_ SPECIAL EDUCATION Clases de educacion especial

\_\_\_\_\_ ENGLISH AS A SECOND LANGUAGE Ingles como segundo idioma

\_\_\_\_\_ SCHOOL WITHIN A SCHOOL escuela entre escuela

LAST SCHOOL ATTENDED Ultima escuela que asistio su nino(a)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NUMBER OF YEARS IN U.S. SCHOOLS Cuantos anos en las escuelas del estados unidos (USA) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HAS YOUR CHILD PREVIOUSLY ATTENDED SUNNYSIDE SCHOOLS? Ha asistido su hijo/a anteriormente en el districto de Sunnyside? \_\_\_\_\_Yes/Si \_\_\_\_\_ NO IF YES ,WHAT SCHOOL? Si, cual escuela? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DO PARENT(S) WORK FOR ANY OF THE FOLLOWING? Trabaja su padres(s) por cualquier de estos lugares:

ANY BRANCH OF THE ARMED FORCES Cualquier ramo del ejercito; ROZA IRRIGATION Districto de riego ROZA;

ANY COMPANY ON THE HANFORD RESERVATION Cualquier compania en la reservacion Hanford;

OUTLOOK IRRIGATION DISTRICT El district de riego de Outlook: S.V.I.D. \_\_\_\_\_ YES//Si \_\_\_\_\_ NO

DID PARENTS OR GUARDIAN MOVE WITHIN THE LAST 36 MONTHS TO WORK OR SEEK WORK IN AGRICULTURE, FISHING, OR RELATED FOOD PROCESSING ACTIVITY? Cambiaron de domicilio los padres o guardian con el alumno dentro de los ultimos 36 meses para trabajar en la labor, agricultura, pesca, o alguna actividad relocanada con ellas? \_\_\_\_\_ NO \_\_\_\_\_ YES//Si IF YES,WHEN? Si la respuesta es afirmativa, cuando fue?

DO YOU LIVE OUTSIDE OF THE SUNNYSIDE SCHOOL DISTRICT? Vive fuera del district de Sunnyside?

\_\_\_\_\_ NO \_\_\_\_\_ YES/SI IF YES, WHERE? Si la respuesta es affirmative, donde?

PROCEDURE FOR ENROLLING STUDENT WITH LIFE -THREATENING CONDITION

 Parent completes Health History part of Registration Form

 Secretary/Counselor checks Health History for Life-Threatening conditions

Parent DID mark a life-threatening condition Parent did NOT mark a life-threatening condition

Secretary/Counselor gives parent the correct

Packet that includes:

\* Parent letter explaining requirements.

\* Health Care Provider letter explaining

requirements

\* “Authorization for Medication” forms

\* “Prescription for Diet” form.

Secretary/counselor informs parent that

Student cannot enroll until:

\* “Authorization for Medication” forms

completed and returned

\* Nurse reviews forms and completes

\* Emergency Care Plan (ECP) with parent.

Parent returns forms and meds (if applicable): Enroll Student

\* Secretary notifies nurse that forms and

meds are at school

\* Nurse reviews forms and meds, and

completes Emergency Care Plan

(ECP) with parents

Yes, Complete NO, NOT COMPLETE

 Needs:

 Medication Forms complete

 Medication

 ECP Complete

Enroll student Enroll student