Health Enrollment Packet 2023-2024

( ) New Enrollee ( ) Returning Student

Student Name: ______________________________________ Grade: __________

Forms needed for all New Enrollment & Re-Enrollment

___ Health Authorization Form
___ Tsaile Dental Sealant
___ Smiles Movement
___ Tsaile Flu Clinic Consent
___ Court Order Protection Order (If any)

(***Official Use Only***)

___ Complete packet / Initial of Registrar Staff Initial: ________ Date: ____________

___ Lacks the following information/documents:

____

____

2nd Notification by: ____________________________________ Date: __________________

If student is new, Please Check off: ____________ NASIS#: ________________

Received by: ____________________________________ Date: __________________

Health Packet Complete: ________________

Lukachukai Community Board of Education, Inc.
"Commitment to Children, Commitment to Progress"
Navajo Route 13
P. O. Box 230
Lukachukai, Arizona 86507
Phone: (928) 787-4400/4406 Fax: (928) 787-4419

Dear Parents/Guardians,

Welcome to the 2023-2024 school year!

Please find our health forms enclosed. Every year we require new forms to be filled out so we can ensure that we have up to date parent/guardian contact information, medication, and any other changes that may have occurred in the past year.

Our number one goal is the safety of our students. If information changes throughout the school year, please notify your school.

- All physicians' orders to administer medication or on a special medical condition during school hours should be renewed for the 2023-2024 school year. If your student requires medications during the school day or has a special medical condition such as allergies, or seizures please contact the health office at your child's school as additional forms may be required.
- Please be aware that the Parental Permission for medication administration form must be signed by a parent or guardian for the nurse/school staff to administer any of the prescription medication.
- Up to date Immunization records are required to be on file in the health office. Please notify your school health office when a new immunization is given in writing via immunization record.
- Physicals are required within the first year of enrollment and to participate in sports throughout the school year.
- All student records are kept confidential.

Completed packets must be returned to Lukachukai Community School.

Stay Healthy

Grade __________ Home Room Teacher ______________

Last Name: ____________ First Name: ____________

HEALTH AUTHORIZATION FORM

SCHOOL YEAR 2023-2024

PURPOSE: To enable parents/guardians to AUTHORIZE emergency treatment for a child who becomes ill or injured while under school authority, when parent's cannot be reached. Upon completion, this form must be returned to the school. The original form and any copies thereof may be used to identify the medical options of the undersigned parent/guardian. **PLEASE COMPLETE ALL THREE SECTIONS!**

Last Name:	First Name:	Middle Initial:	Gender: ☐ M ☐ F	DOB:
NAME OF SCHOOL ATTENDED LAST SCHOOL YEAR:				

SECTION ONE - STUDENT EMERGENCY CONTACT INFORMATION

In the event your child becomes sick or injured and needs to be sent home or to the ER, the school health office will always attempt to reach the Parent/Guardian listed below FIRST. Secondary contacts will be called if the parent/guardian cannot be reached. PLEASE KEEP THESE NUMBERS CURRENT!

Parent/Guardian Name:	Address:	Phone #1
		Phone #2
Check all that apply: ☐ Lives With ☐ Legal Guardian		Phone #3
Parent/Guardian Name:	Address:	Phone #1
		Phone #2
Check all that apply: ☐ Lives With ☐ Legal Guardian		Phone #3

	Emergency Contact List	Relationship	Phone #1	Phone#2	Phone #3
1.					
2.					
3.					
4.					

Siblings in Other Schools

	Name	School	Grade	DOB
1.				
2.				
3.				

SECTION TWO - STUDENT HEALTH HISTORY – Please check appropriate box

☐ **My child has no health conditions including those listed below**

☐ Allergies: ☐ Seasonal	☐ Food (List):	☐ Other Allergy (List):	☐ Has EpiPen prescription
☐ ADD/ADHD	☐ Congenital/Genetic	☐ Ear/Nose/Throat	☐ Pulmonary (Other than Asthma)
☐ Asthma Needs Inhaler at School: Y N	☐ Eye/Vision Wears glasses/contacts: Y N	☐ Diabetes (circle one) Type 1 Type 2	☐ Cardiovascular (List)__________ High Blood Pressure: Y N
☐ Cancer	☐ Dermatologic/Skin	☐ Stomach/GI	☐ Musculoskeletal
Long Term Medications (List):	☐ Eating Disorder	☐ Bladder/GU	☐ Dental/Oral
	☐ Endocrine Other than Diabetes	☐ Hematology/Bleeding Disorders	☐ Psychiatric (List Meds):
☐ Any Other Health Conditions:		☐ Migraines	

SECTION THREE - INSURANCE INFORMATION

Student's Insurance:	Subscribers Name:	ID#

TO GRANT CONSENT

In case of an emergency involving my child AND I CANNOT BE REACHED, I understand emergency medical services will be contacted and my child may be transported to the following Chinle Comprehensive Health Care Facility for emergency medical care:

Hospital: Chinle Comprehensive Health Care Facility	Phone: (928) 674-7001

If, for any reason, NEITHER I NOR THE ABOVE LISTED MEDICAL CARE PROVIDERS OR HOSPITAL CANNOT BE REACHED, I understand that appropriate transport and medical care of my child will be arranged to ANY appropriate medical care provider, hospital or medical facility. This authorization does not cover major surgery unless one other doctor/dentist concurs to the need. Nothing in this section shall be construed to impose liability on any school official or school employee, who in good faith, attempts to comply with this section. It is understood that I will be financially responsible for all emergency care. I authorize the school health office staff to contact my child's providers listed above regarding medical management of my child. I understand information on this card will be shared with appropriate personnel on an as-needed basis only. I, also, understand health screenings (including vision, hearing, height, weight, blood pressure, and BMI) may be done by school health personnel unless I provide the school health office with written notification requesting exclusion from these screenings.

Parent/Guardian Signature: ______________________________ Date: ______________

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service
Health Services Administration

Chinle Comprehensive Health Care Facility
Indian Health Service
P.O. Box PH
Chinle, Arizona 86503

January 19, 2023

Dear Parent or Guardian,

In partnership with your child's school and Give Kids A Smile® (GKAS), the Chinle Service Unit Dental Clinics of the Indian Health Service will be performing free exams with x-rays (if needed), prophylactic cleanings, sealants, and fluoride treatments during March and April of 2023. With your permission, your child can be transported with classmates from the school, be seen by a dentist, and transported back to the school.

Studies have shown that children with poor oral health do not perform as well in school. Oral pain in children has been associated with greater numbers of absences from school and lower Grade Point Averages. Giving permission for your child to have this exam and x-rays (if needed) will enable us to diagnose any oral health problems you may not be aware of. A prophylactic cleaning removes plaque from the teeth and when followed with a fluoride treatment helps increase the strength of tooth enamel making teeth less susceptible to tooth decay. Sealants are applied to grooves on the top surfaces of molar teeth and applied to the pits on all teeth (when pits are found) to prevent bacteria from getting in the grooves and causing tooth decay. Sealants, prophylactic cleanings, and fluoride treatment have all been found to significantly reduce the incidence of tooth decay.

The above procedures are useful and helpful in helping your child have an enjoyable time at school and to reach their learning potential, but most important is regular brushing and flossing of teeth with a fluoridated toothpaste and helping them to avoid drinking sugar containing or diet drinks and eating candy between meals.

After the exam we will mail you a report of our findings and which teeth had sealants placed if they were needed. We will also let you know on the report if further treatment is needed. If further treatment is needed we will call you to offer you an opportunity to schedule your child for an appointment in the dental clinic to get the problem teeth fixed.

We are excited to offer this care in partnership with your child's school and GKAS, and to be able to help your child have optimal oral health. For us to see your child during this event, please fill out the attached forms and return them to your child's teacher.

Respectfully,

Benjamin Glick DMD
Dental Program Director
U.S. Indian Health Service; Navajo Area; Chinle Service Unit

Chinle Dental Clinic
Chinle Hospital
928-674-7152

Pinon Dental Clinic
Pinon Health Center
928-725-9505

Tsaile Dental Clinic
Tsaile Health Center
928-724-3618

Student Information

Student Name: ______________________ Teacher: ________________ School: ________________

DOB: ____________ Census#: __________ CHC#: ____________ Grade: ____________

FAMILY CONTACT INFORMATION:

Please check the check box to indicate primary contact:

☐ Mother / Legal Guardian Name: ______________________________ Home Phone: ____________

Address: ______________________________________ Work Phone: ____________

☐ Father / Legal Guardian Name: ______________________________ Home Phone: ____________

Address: ______________________________________ Work Phone: ____________

Primary Mailing Address: ____

INSURANCE INFORMATION: The Chinle Dental Clinics are part of Indian Health Services. Therefore, they will bill insurance and AHCCCS accordance with Indian Health Service policies. You will not receive a bill or owe any money for this service.

Insurance Company Name: ____

Address: ______________________________________ Group Number: ____________

Employer or Group Insured: ____

Medical History

Allergies: If yes, to what:	☐ Yes	☐ No	Excessive Bleeding:	☐ Yes	☐ No
Liver Disease / Hepatitis	☐ Yes	☐ No	Heart / Vascular Diseases:	☐ Yes	☐ No
Seizures:	☐ Yes	☐ No	Heart Murmur:	☐ Yes	☐ No
Asthma: Use inhaler? If so, what medicine:	☐ Yes	☐ No	Takes medication: If yes, what?	☐ Yes	☐ No

Other Chronic Illness, bad reactions to medicine and treatment: ______________________________

____

I have indicated above any chronic illnesses, allergies and any bad reactions to medicine my child has had in the past.

______________________________________ ____________________

Parent / Guardian name and signature Date

CONSENT FORM

Student's Name: ____ DOB: ____________________

1. I want my child to be seen during this event and give permission to the following to be performed, indicated by my initials in the line in front of each paragraph:

_______ **Dental x-rays** allow the dentist to diagnose and treat conditions that cannot be detected by the eye during a clinical examination. Dental x-ray films detect more than cavities. For example, x-rays may be needed to assess erupting teeth, diagnose bone diseases, or evaluate the results of an injury. If dental problems are found and treated early, before they become visible or painful, dental care is much more comfortable. Dental x-rays are a part of a comprehensive oral examination. The dose of radiation is minimal from dental x-rays, and all necessary precautions will be taken to ensure exposure is minimal (lead apron, collar and digital imaging). We will only take the necessary x-rays to obtain a good diagnosis. Dental x-rays have been shown to be safe at the frequency and dosing recommended by the American Dental Association. If you do not consent for us to take to x-rays we can still perform a limited exam, but may not be able to see and diagnose existing conditions, and this could lead to future pain and loss of teeth. (Please initial on the line if consenting).

_______ **Dental examination** performed by licensed I.H.S. Dentist. We can't fix it, if we don't know what is broken. This examination will include looking closely at the teeth for caries, evaluating the health of the gums, include an oral cancer screening, evaluation and interpretation of x-rays, evaluation of the TMJ and orthodontic relationships. (Please initial your consent for the dentist to perform a dental exam).

_______ **Dental prophylaxis (teeth cleaning)** is a cleaning procedure performed to thoroughly clean tarter and dental plaque from the teeth. Removal of plaque and tarter (rough & hard calcifications) from the teeth helps prevent tooth decay and makes fluoride and sealant application more effective. (Initial to give your consent for us to perform a prophylactic dental cleaning).

_______ **Fluoride varnish** is effective in preventing and reversing the early signs of dental caries (tooth decay). Fluoride incorporates into the tooth structure making it stronger resulting in teeth that are more resistant to decay. Fluoride also acts to repair areas in which minor decay may have already begun. Fluoride treatments are most effective when applied after all the plaque and build up have been removed from teeth during a dental cleaning. With consent we will apply fluoride to your child's te eth after they are cleaned. (If you do not consent, we will perform the cleaning and not apply Fluoride varnish).

_______ **Dental sealants** are "plastic like" materials placed in the pits and fissures (grooves) of teeth to prevent bacteria from growing in the "crevices" and causing caries. Pits and fissures of teeth are often difficult areas to get clean, and often the bristles of the brush may not even be able to enter these pits and fissures to remove dental plaque. Dental sealant is used to fill in these "Crevices" to keep plaque out. Dental sealants have been shown to be safe and very effective at reducing decay rates. Regular checkups are important to ensure sealants are not broken which could lead to dental decay. The application of sealants is painless, but as with any dental procedure sometimes gagging or swallowing of dental materials (non-toxic) could occur. For a few days after sealant placement your child may notice minor changes to their bite, this will become less noticeable as the excess sealant material wears away over time. (If you would like us to place dental sealants, on any teeth that they are indicated for, please place your initials on the appropriate line).

____ ____________________

Parent / Guardian Name and Signature Date

The Smiles Movement

PO Box 767
Camp Verde, AZ 86322

thesmilesmovement@gmail.com

Ph: 928-567-1832
Fax: 928-567-6500

Please return this form to the school!

DEAR CONCERNED PARENT:

Dental disease is the #1 reason children miss school. The Smiles Movement has been providing care for your children for over 30 years at no charge to you. You have a choice; you can choose to go through the process at IHS, or enjoy the convenience of having our experienced doctors care for your child at their school. We thank you for once again choosing our practice that over the years has served thousands of children. To participate, your child must be enrolled in an appropriate AHCCCS program which is easily done at most IHS facilities.

IF YOU CHOOSE TO HAVE YOUR CHILD CONSIDERED FOR TREATMENT YOU MUST COMPLETE THE FOLLOWING:

Child's Name________________________________Male______Female______

Child's Social Security Number____________________Date of Birth____/____/____

Emergency Contact____________________________Phone #________________

School Name____________________Teacher's Name________________Grade_____

HEALTH HISTORY

PLEASE TELL US ABOUT YOUR CHILD'S HEALTH HISTORY. CHECK ALL OF THE FOLLOWING THAT APPLY TO YOUR CHILD:

Has your child had?	NO	YES
Allergy to medication	____	____
Rheumatic Fever	____	____
Psychiatric Treatment	____	____
Seizure Disorder	____	____
Diabetes	____	____
AIDS/HIV Positive	____	____
Hospitalizations	____	____
Vision or speech problems	____	____
Could your child be pregnant?	____	____

	NO	YES
Heart Murmur	____	____
Bleeding Disorders	____	____
High Blood Pressure	____	____
Asthma	____	____
Hepatitis/Jaundice	____	____
Anemia	____	____
Latex Allergy	____	____
Other Serious Illness	____	____

Is your child under a Physician's care? NO____YES____
Is your child taking any medication? ____ ____
Any problems with local anesthetic? ____ ____

PLEASE EXPLAIN ANY "YES" ANSWERS:____

What is your primary concern for your child's oral health?________________________

____

PLEASE TURN OVER AND COMPLETE

CONSENT FOR TREATMENT AND PATIENT MANAGEMENT

Following your child's examination, that consists of radiographs (x-rays) and in some cases, a panoramic scan, and cleaning, the doctor may determine that your child requires additional dental treatment, including silver fillings, routine baby tooth extractions, stainless steel crowns, and pulp treatments for deciduous (baby) teeth. These pulp treatments are routine procedures for baby teeth. More involved pulp treatments for permanent teeth (root canals) are referred.

The Smiles Movement dentists make all decisions very carefully, including referring your children who may benefit from sedation, protecting your child from injury with a gentle hand, or in the event of a critical situation, briefly using a papoose board similar to those used by physicians and hospitals. It is always our priority to give your child excellent dental care, protect them, and create a pleasant visit. These efforts will help insure positive dental experiences for a lifetime of smiles. If our dentists make the decision to refer your child, they take all factors into consideration, including the very limited number of general anesthesia appointments available at the IHS. We coordinate our schedules with the school nurse, and we welcome and encourage you to participate, however, we do understand that in some circumstances you cannot attend.

We have had great success with our program and we are looking forward to providing your child with excellent dental care. Participation in this program could affect future benefits your child may receive under private insurance or from another private dentist.

- HELP US COMBAT DENTAL DISEASE, THE #1 CAUSE OF MISSED SCHOOL TIME
- WE WANT TO GIVE YOUR CHILD A SMILE THAT LASTS A LIFETIME

CONSENT FOR TREATMENT
AND
AKNOWLEDGEMENT OF PRIVACY PRACTICES

By signing below I acknowledge that: (Please check one below)

1.______ YES. I give permission for my child to receive necessary treatment!
I am aware that I have rights outlined in the Notice of Privacy Practices and that a copy of this notice is available for my review.
I consent to the sharing of this information with the IHS Dental program.

2.______ No. I do not want my child to receive necessary dental treatment provided at their school. I will assume responsibility for obtaining their treatment elsewhere.

I understand that I may refuse to sign this Consent and Acknowledgement.

X____ Date____________________________

Parent or Guardian

Please print your name____

If you have any questions, please call our office at 928-567-1832

PLEASE TURN OVER AND COMPLETE

CHINLE SERVICE UNIT

Parent CONSENT for 2023 SEASONAL FLU and COVID-19 VACCINE for STUDENTS

Photocopy on white only.
Scanned into patient chart.

SCHOOL: ______________________ **GRADE:** ______ **TEACHER:** ___________________________

The clinic will be provided by Chinle Service Unit. Everyone aged 6 years and older should get 1 updated **Pfizer-Biotech COVID-19** vaccine to be up to date. Children aged 6 months to 5 years may need multiple doses of the COVID19 vaccine to be up to date including at least 1 dose of the updated Pfizer-Biotech COVID-19. The **seasonal flu shot** is recommended annually for all school students. If you would like your child to receive the seasonal flu vaccine and/or the COVID-19 vaccine to stay up to date **at school** this year, please complete and **sign** this consent. **Only students with a signed consent will receive a seasonal flu and COVID-19 vaccine at the school clinic.**

If you DO NOT want your child to receive ANY vaccines, DO NOT turn in this form!

INFORMATION ABOUT MY CHILD (Please print clearly)

Name: Last: ____________________________ **First:** ___________________________ **MI:** ___ **Age:** ________

Birth Date: ____________________________ **Child's Gender: Male Female** **Child's Health Record #** ____________

Health Care Facility Used: ____________________________ **Child's Social Security # (last 4 digits only)** ___________

Parent/Guardian Name: ___________________________________ **Day Time Phone:** __________________

Mailing Address: Box: _______________ **City:** ______________________ **State:** ______ **Zip:** ___________

Physical Location of Home: ____

Parents: Please check/circle the box for the vaccine the child will be receiving, then answer additional questions:

Influenza Vaccine: [ ] **YES, I want my child to receive the current recommended seasonal FLU vaccine**
[ ] **NO, I do not want my child vaccinated**

COVID-19 Vaccine: [ ] **YES, I want my child to receive the current recommended COVID vaccine**
[ ] **NO, I do not want my child vaccinated**

If yes, please answer the following questions:

1. **Is your child allergic to eggs or other vaccine ingredients?**........ [ ] YES [ ] NO
2. **Has your child ever had a serious reaction to a flu (influenza) or COVID shot?**........ [ ] YES [ ] NO
3. **Has your child ever had a serious reaction to another vaccine or injectable medication?**..... [ ] YES [ ] NO
4. **Has your child ever had an allergic reaction to a previous dose of COVID-19 vaccine or an ingredient in the COVID-19 vaccine (polyethylene glycol or polysorbate)?**........ [ ] YES [ ] NO
5. **Has your child ever had a serious allergic reaction to anything?**........ [ ] YES [ ] NO
   List Allergies: ____
6. **Does your child have a health condition which makes them immunocompromised?** .... [ ] YES [ ] NO
7. **Has your child ever had Guillain-Barre' Syndrome?** .... [ ] YES [ ] NO
8. **Does your child have history of myocarditis or pericarditis?** .... [ ] YES [ ] NO
9. **Has your child been diagnosed with Multisystem Inflammatory System (MIS-A)/MIS-C** .... [ ] YES [ ] NO
10. **Does your child have history of immune-mediated syndrome, such as heparin-induced thrombocytopenia (HIT)?** .... [ ] YES [ ] NO
11. **Does your child have history of Thrombosis with thrombocytopenia?** .... [ ] YES [ ] NO
12. **Has your child ever received a dose of COVID-19 vaccine?** .... [ ] YES [ ] NO
    a. [ ] Pfizer [ ] other brand ______________ **b. How many doses were received?** ______________

If you answered "yes" to #2, 3, 4, 5, 6, 7, 8, 9, 10, or 11, please talk to your child's provider for further evaluation.

I certify that I am the parent or Legal Guardian of the child named above. I am legally authorized to request vaccination of the child with the seasonal flu and/or COVID-19 vaccine. I have read the Vaccine Information Statement and/or Emergency Use Authorization Fact Sheet (see attached), about the seasonal flu and/or COVID-19 vaccine. I authorize a medical provider to assess my child, if needed, prior to my child's flu/COVID-19 vaccination. I have had the opportunity to ask questions about the benefits and risks of the seasonal flu/COVID 19 vaccination. My questions, if any, have been answered.

Parent/Guardian Signature: ___________________________________ **Date:** ______________

Patient Identification:

CSU-178________

Lukachukai Community Board of Education, Inc.
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Lukachukai, Arizona 86507
Phone: (928) 787-4400/4406 Fax: (928) 787-4419

School Year 2023-2024

Dear Parents, Caregivers, and Guardians,

We know that last year was tough, but we're excited to get back in the classroom this fall. We are committed to taking the steps necessary to help us have a safe return to school. As part of steps to help stop the spread of COVID-19 and keep our school open for in-person learning, we will offer a **free COVID-19 Testing Program for students and staff at Lukachukai Community School**. Regular testing will help protect our students, staff, family members, and others who are not vaccinated against COVID-19 or are otherwise at risk for getting seriously sick from COVID-19.

Through this program, we will be able to identify COVID-19 cases quickly and early, which can help us stop an outbreak before it happens. This will help us keep students in the classroom and able to take part in the school activities they love.

We are working with the Chinle IHS Health Promotion Disease Prevention Department within the Division of Public Health and are joining other school districts throughout the state that offer this program.

- **Who will be tested?** We will offer testing to everyone—all students and staff—even if they don't have symptoms of COVID-19.
  - [If applicable] Testing is also available for students and staff who have symptoms of COVID-19, even if vaccinated, or who have been in close contact with someone with COVID-19.
- **How is the testing done?** The COVID-19 testing is free, quick, and easy. Members of our school staff will oversee testing with [either a NAAT/PCR or antigen] test, which includes:
  - [For nasal tests] Gently swabbing the inner part of the lower nostril. This test is not painful. We do not use the longer swabs that reach higher into the nose.
- **Where and when is the testing done?** Our school's testing site will be in the school nurse's office and will take place regularly. Results will be available within 15 minutes.
- **How can I be sure that my child's information will be protected?** Sharing of information about your child will only be done for public health purposes and in accordance with applicable law and policies protecting student privacy and the security of your child's data.

This letter asks your permission for us to:

- **regularly test your child as part of a free COVID-19 testing program at school, and**
- **test your child if they show symptoms consistent with COVID-19 or have been in close contact with a person with COVID-19 while in school.**

To learn more, please email sjones-brown@lukaschool.org.

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We are extremely grateful to our committed families and staff who continue to show great flexibility and resilience as we work together to contain the spread of this virus. If you have questions regarding the COVID-19 Testing Program, please reach out to our School CNA, Susie Jones-Brown, or to our interim Principal, Charlotte Begay.

Sincerely,

Charlotte Begay, Interim Principal
Lukachukai Community School
(928) 787-4418

☐ I authorize my child, ____________________________, to participate in the Covid-19 Testing Program.

☐ I do not authorize my child, ____________________________, to participate in the Covid-19 Testing Program and understand that my child may need to attend school virtually.

______________________________ Parent Signature

______________________________ Date

CDC recommends everyone ages 5 years and older get a COVID-19 vaccine to help protect against COVID-19. COVID-19 vaccines are safe, effective, and free. Getting vaccinated prevents severe illness, hospitalizations, and death. Visit vaccines.gov to find vaccination providers near you.