June 1, 2019

Dear Parents,

Welcome to the Grosse Pointe Academy! Now is the time when we begin the necessary paperwork for next year.

Your child is required to have a school physical completed for the 2019-2020 school year. Enclosed is a green Health Appraisal form for your child’s physician to fill out both sides, and sign the back. The physical must be dated after June 7, 2019 or it will not be accepted. The Personal Section and Section I Health History need to be filled out and signed by a parent.

Have your physician complete the Asthma and/or Allergy Emergency Care Plan ONLY if your child(ren) has any of these conditions. Remember if an Epi-pen or inhaler is prescribed, there must be 2 on campus at all times.

If your child is in 5th–8th grade, a sport physical form is also included.

Remember that summer appointments for routine well-child physicals are often scheduled many weeks in advance. Therefore, please call for your child’s appointment at your earliest convenience.

These forms must be returned to the school for processing before Friday, August 16, 2019. The Michigan Department of Health will enforce mandatory exclusion from school for those children who do not verify immunization records through this completed Health Appraisal form.

Thank you for your cooperation in this very important matter.

Sincerely,

Rosemary Barker, BSN, RN
School Nurse
Required Emergency/Medical Forms List
2019 – 2020

Every year there are questions as to what student needs to turn in what paperwork to the nurse before the beginning of the new school year. Below is a list by division or grade to help clarify this process. 

Note: All of these forms are required every year. Please pay attention to detail and fill out and sign all forms.

Early School Students need the following paperwork turned in to the office before school starts:
♦ White Child Information Record State of Michigan Card
♦ Green Health Appraisal Form with Immunization Record
♦ Blue Medication permission form
♦ If your child has Asthma or Allergies the Emergency Care Plans
♦ Heads Up Concussion form
♦ Consent for Disclosure of Immunization Information

Grades 1-4 Students need the following paperwork turned in to the office before school starts:
♦ The Grosse Pointe Academy Family Emergency Information Card: Grades 1-8 Card
♦ Blue Medication permission form
♦ If your child has Asthma or Allergies the Emergency Care Plans
♦ Heads Up Concussion form
♦ Consent for Disclosure of Immunization Information

Grade 5 Students need the following paperwork turned in to the office before school starts:
♦ The Grosse Pointe Academy Family Emergency Information Card: Grades 1-8 Card
♦ Blue Medication permission form
♦ If your child has Asthma or Allergies the Emergency Care Plans
♦ White Sports physical exam/clearance/consent form (if playing a sport)
♦ Heads Up Concussion form
♦ Consent for Disclosure of Immunization Information

Grade 7 Students need the following paperwork turned in to the office before school starts:
♦ The Grosse Pointe Academy Family Emergency Information Card: Grades 1-8 Card
♦ Green Health Appraisal Form with Immunization Record
♦ Blue Medication permission form
♦ If your child has Asthma or Allergies the Emergency Care Plans
♦ White Sports physical exam/clearance/consent form
♦ Heads Up Concussion form
♦ Consent for Disclosure of Immunization Information

Grade 6 & 8 Students need the following paperwork turned in to the office before school starts:
♦ The Grosse Pointe Academy Family Emergency Information Card: Grades 1-8 Card
♦ Blue Medication permission form
♦ If your child has Asthma or Allergies the Emergency Care Plans
♦ White Sports physical exam/clearance/consent form
♦ Heads Up Concussion form
♦ Consent for Disclosure of Immunization Information

Most forms are available at gpacademy.org under the password protected forms tab click on medical forms
**HEALTH APPRAISAL**

Dear Parent or Guardian: The following information is requested so that the school can work with the parent to meet the physical, intellectual and emotional needs of the child. Fill out the information requested in Section I. Section III may be certified by the transcription of information from the certificate of immunization. The remaining sections are to be completed by a doctor, nurse and dentist. **(BE SURE TO BRING YOUR CHILD’S IMMUNIZATION RECORDS TO THE EXAMINATION)**

### PERSONAL

<table>
<thead>
<tr>
<th>CHILD’S NAME (Last, First, Middle)</th>
<th>DATE OF BIRTH (mm/dd/yy)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADDRESS (Number &amp; Street)</td>
<td>(City)</td>
</tr>
<tr>
<td></td>
<td>(Zip Code)</td>
</tr>
<tr>
<td>PARENT/GUARDIAN (Last, First, Middle)</td>
<td>TODAY’S DATE (mm/dd/yy)</td>
</tr>
<tr>
<td>ADDRESS (Number &amp; Street)</td>
<td>(City)</td>
</tr>
<tr>
<td></td>
<td>(Zip Code)</td>
</tr>
</tbody>
</table>

### SECTION I - HEALTH HISTORY

<table>
<thead>
<tr>
<th>No</th>
<th>Yes/No</th>
<th>Reasoned</th>
<th># Is your child having any of the problems listed below?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>1. Allergies or Reactions (for example, food, medication or other)</td>
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<td></td>
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<td>2. Hay Fever, Asthma, or Wheezing</td>
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<td></td>
<td>3. Eczema or Frequent Skin Rashes</td>
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<td>4. Convulsions/Seizures</td>
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<td></td>
<td>5. Heart Trouble</td>
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<td>6. Diabetes</td>
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<td></td>
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<td></td>
<td>7. Frequent Colds, Sore Throats, Earaches (4 or more per year)</td>
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<td></td>
<td>8. Trouble with Passing Urine or Bowel Movements</td>
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<td></td>
<td></td>
<td>9. Shortness of Breath</td>
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<td></td>
<td></td>
<td></td>
<td>10. Speech Problems</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>11. Menstrual Problems</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>12. Dental Problems: Date of Last Exam</td>
</tr>
</tbody>
</table>

![Image](https://via.placeholder.com/150)

<table>
<thead>
<tr>
<th>Birth History:</th>
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</thead>
<tbody>
<tr>
<td>Are there any current or past diagnosis(es)?</td>
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<tr>
<td>Yes</td>
</tr>
<tr>
<td>If yes, please describe:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reason for Medication</th>
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<tbody>
<tr>
<td>Was the health history reviewed by a health professional?</td>
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<tr>
<td>Yes</td>
</tr>
</tbody>
</table>

**Parent/Guardian Signature**

**Date**

**Examiner’s Initials**

### SECTION II - PHYSICAL EXAMINATION, INSPECTION, TESTS AND MEASUREMENTS

**Required for Child Care and Head Start / Early Head Start**

<table>
<thead>
<tr>
<th>Tests and Measurements</th>
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<tbody>
<tr>
<td>Was child tested for:</td>
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<tr>
<td>Test results:</td>
</tr>
<tr>
<td>Hearing</td>
</tr>
<tr>
<td>Vision</td>
</tr>
<tr>
<td>Urinalysis</td>
</tr>
<tr>
<td>Blood Lead Level</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date</th>
<th>Test results:</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Visual Acuity</td>
</tr>
<tr>
<td></td>
<td>Muscle Imbalance</td>
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<tr>
<td></td>
<td>Audimeter</td>
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<td></td>
<td>Sugar</td>
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<td></td>
<td>Level ug/dl</td>
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</tbody>
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<thead>
<tr>
<th>Date</th>
<th>Test results:</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Height &amp; Weight</td>
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<tr>
<td></td>
<td>Height</td>
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<tr>
<td></td>
<td>Weight</td>
</tr>
<tr>
<td></td>
<td>Blood Pressure</td>
</tr>
<tr>
<td></td>
<td>Reading:</td>
</tr>
<tr>
<td>Date</td>
<td>Test results:</td>
</tr>
<tr>
<td></td>
<td>Hemoglobin / Hematocrit</td>
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<tr>
<td></td>
<td>Type:</td>
</tr>
<tr>
<td>Date</td>
<td>Test results:</td>
</tr>
<tr>
<td></td>
<td>Tuberculin Type:</td>
</tr>
<tr>
<td>Date</td>
<td>Test results:</td>
</tr>
<tr>
<td></td>
<td>Album:</td>
</tr>
<tr>
<td>Date</td>
<td>Test results:</td>
</tr>
<tr>
<td></td>
<td>Microscopic:</td>
</tr>
</tbody>
</table>

**NOTE:** Blood lead level required for all children enrolled in Medicaid must be tested at one and two years of age, or once between three and six years of age if not previously tested. All children under age six living in high-risk areas should be tested at the same intervals as listed above.

<table>
<thead>
<tr>
<th>Examinations and/or inspections</th>
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<table>
<thead>
<tr>
<th>Date</th>
<th>Examinations and/or inspections</th>
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<table>
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<tr>
<th>Exam Date</th>
<th></th>
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MOCH/BCAL-3305 (formerly OCAL 3305/EPIS-3305)

Page 1 of 2

Rev. August 2013
SECTION III - IMMUNIZATIONS

Statements such as "UP-TO-DATE" or "COMPLETE" will not be accepted. Admission to school may be denied on the basis of this information.

<table>
<thead>
<tr>
<th>VACCINES (Circle Type)</th>
<th>DATE ADMINISTERED</th>
<th>VACCINES (Circle Type)</th>
<th>DATE ADMINISTERED</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MM/DD/YYYY</td>
<td></td>
<td>MM/DD/YYYY</td>
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<tr>
<td>Hepatitis B</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(HepB)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>1</td>
<td>3</td>
<td></td>
<td></td>
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<tr>
<td>DTaP/DTP/DT/Td</td>
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<tr>
<td>1</td>
<td>4</td>
<td></td>
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<tr>
<td>Tdap</td>
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<td></td>
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<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Hemophilus Influenza</td>
<td></td>
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<td></td>
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<tr>
<td>type b (HIB)</td>
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<td></td>
<td></td>
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<tr>
<td>1</td>
<td>3</td>
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<td></td>
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<tr>
<td>Polio</td>
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<td>1</td>
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<td></td>
<td></td>
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<tr>
<td>(IPV/OPV)</td>
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<td>1</td>
<td>2</td>
<td></td>
<td></td>
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<tr>
<td>Pneumococcal Conjugate</td>
<td></td>
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<tr>
<td>(PCV7/PCV13)</td>
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<tr>
<td>1</td>
<td>3</td>
<td></td>
<td></td>
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<tr>
<td>Rotavirus (RV1/RV5)</td>
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<td></td>
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<tr>
<td>1</td>
<td></td>
<td></td>
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<tr>
<td>Measles, Mumps, Rubella(MMR)</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Varicella (Chickenpox)</td>
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<tr>
<td>1</td>
<td>2</td>
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'Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable

* NOTE: According to Public Act 389 of 1978, any child enrolling in a Michigan school for the first time must be adequately immunized, vision tested, and hearing tested. Exemptions to these requirements are granted for medical, religious, and other reasons, provided that the waiver forms are properly completed and delivered to school administrators. Forms for these exemptions are available at your child's school or local health department.

Parent/Guardian refused immunizations: ☐

Health Professional's Signature: __________________________ Title: __________ Date: __________

SECTION IV - RECOMMENDATIONS

(Required for Child Care and Head Start/Early Head Start)

☐ ☐: Is there any other condition for which the school should be informed of? If yes, please explain:

☐ ☐: Should the child's activity be restricted because of any physical defect or illness? If yes, please explain:

☐ ☐: Classroom ☐ Playground ☐ Gymnasium ☐ Swimming Pool ☐ Competitive Sports ☐ Other

Other Recommendations: __________________________

SECTION V - DENTAL EXAMINATION AND RECOMMENDATIONS (OPTIONAL)

I have examined __________________________'s teeth. As a result of this examination, my recommendation for treatment is:

Dentist's Signature: __________________________ Date: __________

PHYSICIAN'S SIGNATURE

Examiner's Signature: __________________________ Date: __________

Examiner's Name (Print or Type): __________________________

Degree or License: __________________________

Number & Street: __________________________

City: __________________________ State: __________

ZIP Code: __________________________ Telephone: __________________________

Information required for:

Early On - Hearing and Vision Status: Diagnosis; Health Status

Child Care Licensing - Physical Exam, Restrictions, Immunizations

Head Start/Early Head Start - Determination that child is up-to-date on a schedule of age-appropriate preventive and primary health care, including medical, dental, and mental health. The schedule must incorporate the well-child care visit required by EPSDT and the latest immunizations schedule recommended by the Centers for Disease Control and Prevention, State, tribal, and local authorities. An EPSDT well-child exam includes height, weight, and blood tests for anemia at regular intervals based on age.

MEDICAL HISTORY: 

Student Name: ___________________________ Date of Exam: ___________________________

Family Doctor: ___________________________ Phone: ___________________________

GENERAL INFORMATION

Digitalrometer: 

Do you cough, wheeze or have difficulty breathing during or after exercise?

Do you ever use an inhaled or taken asthma medicine?

Has there anyone in your family who has asthma?

Have you been recently treated or seen by a medical professional?

Have you ever been hospitalized or been treated for a heart condition?

Have you ever had a heart attack or been treated for a cardiac rhythm problem?

Have you ever had a heart transplant or been treated for a heart rhythm problem?

Have you ever had a heart rhythm problem treated by a pacemaker or defibrillator?

Has anyone in your family have a heart rhythm problem or been treated for a heart rhythm problem?

Is anyone in your family has had a heart surgery or heart transplant?

Has anyone in your family have a heart condition or been treated for a heart condition?

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Has anyone in your family have a heart condition or been treated for a heart condition?
PRE-PARTICIPATION PHYSICAL - CONSENT - INSURANCE

Student Name: ____________________________________________

Student Address: ____________________________________________

Gender: □ M □ F

Date of Birth: ___________ Place of Birth (City/State): ___________

School: ____________________________________________

Father/Guardian Name: ____________________________________________

Phone (home): ______________________________ (work): ______________________________

Mother/Guardian Name: ____________________________________________

Phone (home): ______________________________ (work): ______________________________

Email Address: Parent/Guardian/18-Year-Old:

STUDENT PARTICIPATION & PARENT or GUARDIAN or 18-YEAR-OLD CONSENT:

The information submitted herein is truthful to the best of my knowledge. By my/my child’s signature below, I/we acknowledge that I/we have received concussion educational information that meets Michigan Department of Health and Human Services and MHSAA requirements.

Further, in consideration of my/my child’s participation in MHSAA-sponsored athletics, I/we hereby agree, understand, appreciate, and acknowledge that participation in such athletics is purely voluntary; that such activities involve physical exertion and contact and that there is inherent risk of personal injury associated with participation in such activities, which risk I/we assume; and that I/we agree to, and hereby waive any and all claims, suits, losses, actions, or causes of action against the MHSAA, its members, officers, representatives, committee members, employees, agents, attorneys, insurers, volunteers, and affiliates based on any injury to me, my child, or any person, whether because of inherent risk, accident, negligence, or otherwise, during or arising in any way from my/my child’s participation in an MHSAA-sponsored sport.

I/we understand that I/am/we are expected to adhere firmly to all established athletic policies of my school district and the MHSAA. I/we hereby give my consent for the above student to engage in interscholastic athletics and for the disclosure to the MHSAA of information otherwise protected by FERPA and HIPAA for the purpose of determining eligibility for interscholastic athletics. My child has my permission to accompany the team as a member on its out-of-town trips.

Signature of STUDENT: ____________________________________________ Date: __________________________

Signature of PARENT or GUARDIAN or 18-YEAR-OLD: ____________________________________________ Date: __________________________

INSURANCE STATEMENT

Our son/daughter will comply with the specific insurance regulations of the school district.

The student-athlete has health insurance: □ YES □ NO

If YES, Family Insurance Co: ____________________________ Insurance ID #: ____________________________

Additionally, I hereby state that, to the best of my knowledge, my answers to the medical history questions (see reverse) are complete and correct.

Signature of PARENT or GUARDIAN or 18-YEAR-OLD: ____________________________________________ Date: __________________________

MEDICAL TREATMENT CONSENT, COMPLETED BY PARENT or GUARDIAN or 18-YEAR-OLD

I, ____________________________________________, an 18-year-old, or the parent or guardian of ____________________________________________, recognize that as a result of athletic participation, medical treatment on an emergency basis may be necessary, and further recognize that school personnel may be unable to contact me for my consent for emergency medical care. I do hereby consent in advance to such emergency care, including hospital care, as may be deemed necessary under the then-existing circumstances and to assume the expenses of such care.

Signature of PARENT or GUARDIAN or 18-YEAR-OLD: ____________________________________________ Date: __________________________
Release for Dispensing of Medication

In the past, there have been innumerable times when students have reported to the school nurse complaining of a headache, sore throat, or cough. Most times Tylenol, Motrin or cough drops can be administered and the student can return to his/her classroom and complete the school day. Therefore, we are sending release to each family giving you the opportunity to grant your written permission for the school nurse to dispense the appropriate medications.

The “stock” medication, which will be kept in the nurse’s office and dispensed, will be (over - the counter medications):
Tylenol or Motrin
Benadryl 2% cream for itch relief
Triple Antibiotic/Neosporin Pain Relief
Tums antacid tablets
Cough drops

We, the undersigned parent and/or guardian of:

______________________________  __________________________  __________________________
Child’s Name (Please Print)      Date of Birth          Grade          Weight

do hereby and execute this release on behalf of us and on behalf of our minor son/daughter/ward. We hereby waive any liability whatever to The Grosse Pointe Academy or any of its personnel, that might occur as the result of giving said medication per manufacturer dosage instructions to our minor son/daughter/ward. I agree to indemnify and hold harmless The Grosse Pointe Academy, and its affiliated entities, successors and assigns, directors, officers, trustees, employees, agents, and representatives, including volunteers, from any and all claims, including negligence, which may be asserted by my child or me, or on behalf of my child, arising from or relating to the Academy’s administration of medication in accordance with the above directives.

______________________________  __________________________
Parent’s Signature          Date

______________________________
Print Parent’s Name

Please note: Medications cannot be dispensed to any student without the above indicated written permission. If you prefer your child to receive another medication other than the medications listed above, the parent must provide it, and also complete the reverse side of this form.

Please complete this form and return to the School Office on or prior to the first day of school. See reverse and complete applicable
Permission Form for Prescribed Medication

To be completed by Parent or Guardian:

Name of Medication: ____________________________________________

Reason for Medication: ________________________________________

Form of Medication/Treatment:
  o Tablet/Capsule  o Liquid  o Inhaler  o Nebulizer  o Other

Instructions: (Schedule, dose, and duration to be given at school)
________________________________________________________________
________________________________________________________________
________________________________________________________________
________________________________________________________________

Restrictions and/or important side effects:  o None anticipated
  o Yes, please describe:
________________________________________________________________
________________________________________________________________
________________________________________________________________

Special Storage Requirements:  o None  o Refrigerate

This student may carry medication:  o No  o Yes
(The school policy does not permit children to self-medicate EXCEPT for the use of inhalers for asthma or Epi Pen for several allergies. Similarly, we recommend sending an extra inhaler to be stored in the nurse’s office in case the child has lost or misplaced his/her inhaler. 2 Epi Pens are still required to be stored on campus.)

Physician’s Name: _________________________________ Phone Number: ____________

I request that (name of child) __________________________________________ receive the above medication at school according to standard school policy. I understand that I must send the medication to school in the pharmacy bottle/container labeled with your child's name, name of the medication, dosage, and times for administration. I assume all risk of any sickness, injury, and/or reaction sustained as a result of my instructions. We hereby waive any liability, claims, losses, and expenses whatever to The Grosse Pointe Academy or any of its personnel, that might occur as the result of giving said medication in the indicated dosage at the time requested to our minor son/daughter ward.

Parent’s Signature: _________________________________ Date: ________________
The Grosse Pointe Academy

Consent for Disclosure of Immunization Information to Local and State Health Departments

Immunizations are an important part of keeping our children healthy. Schools and State and Local health departments must monitor immunization levels to ensure that all communities are protected from potentially life-threatening diseases and, if necessary, respond promptly to an emerging public health threat. It is important that disease threats be minimized through the monitoring of students being immunized.

Sharing immunization and personally identifiable information including the students' name, Date of Birth, gender, and address with local and state health departments will help to keep your child safe from vaccine preventable diseases. The Family Educational Rights and Privacy Act (FERPA), 20 U.S.C. § 1232g, requires written parental consent before personally identifiable information from your child's education records is disclosed to the health department. If your child is 18 or over, he or she is an "eligible student" and must provide consent for disclosures of information from his or her education records.

You may withdraw your consent to share this information in writing at any time.

I authorize The Grosse Pointe Academy to release my child's immunization record to the Michigan Department of Health and Human Services and Local Health Department. I understand this information will be used to improve the quality and timeliness of immunization services and to help schools comply with Michigan Law. This includes any immunization information and limited personally identifiable information from the school.

Student’s Name: ___________________________________________ Date of Birth: __/__/__

Signature of Parent/Guardian or Eligible Student: ___________________________ Date: __/__/__

Printed Parent/Guardian Name: ___________________________________________
This sheet has information to help protect your children or teens from concussion or other serious brain injury. Use this information at your children's or teens' games and practices to learn how to spot a concussion and what to do if a concussion occurs.

What Is a Concussion?
A concussion is a type of traumatic brain injury—or TBI—caused by a bump, blow, or jolt to the head or by a hit to the body that causes the head and brain to move quickly back and forth. This fast movement can cause the brain to bounce around or twist in the skull, creating chemical changes in the brain and sometimes stretching and damaging the brain cells.

How Can I Help Keep My Children or Teens Safe?
Sports are a great way for children and teens to stay healthy and can help them do well in school. To help lower your children's or teens' chances of getting a concussion or other serious brain injury, you should:

- Help create a culture of safety for the team.
  - Work with their coach to teach ways to lower the chances of getting a concussion.
  - Talk with your children or teens about concussion and ask if they have concerns about reporting a concussion. Talk with them about their concerns; emphasize the importance of reporting concussions and taking time to recover from one.
  - Ensure that they follow their coach's rules for safety and the rules of the sport.
  - Tell your children or teens that you expect them to practice good sportsmanship at all times.
- When appropriate for the sport or activity, teach your children or teens that they must wear a helmet to lower the chances of the most serious types of brain or head injury. However, there is no "concussion-proof" helmet. So, even with a helmet, it is important for children and teens to avoid hits to the head.

How Can I Spot a Possible Concussion?
Children and teens who show or report one or more of the signs and symptoms listed below—or simply say they just "don't feel right" after a bump, blow, or jolt to the head or body—may have a concussion or other serious brain injury.

Signs Observed by Parents or Coaches
- Appears dazed or stunned
- Forgets an instruction, is confused about an assignment or position, or is unsure of the game, score, or opponent
- Moves clumsily
- Answers questions slowly
- Loses consciousness (even briefly)
- Shows mood, behavior, or personality changes
- Can't recall events prior to or after a hit or fall

Symptoms Reported by Children and Teens
- Headache or "pressure" in head
- Nausea or vomiting
- Balance problems or dizziness, or double or blurry vision
- Bothered by light or noise
- Feeling sluggish, hazy, foggy, or groggy
- Confusion, or concentration or memory problems
- Just not "feeling right," or "feeling down"

Talk with your children and teens about concussion. Tell them to report their concussion symptoms to you and their coach right away. Some children and teens think concussions aren't serious, or worry that if they report a concussion they will lose their position on the team or look weak. Be sure to remind them that it's better to miss one game than the whole season.

cdc.gov/HEADSUP
CONCUSSIONS AFFECT EACH CHILD AND TEEN DIFFERENTLY.

While most children and teens with a concussion feel better within a couple of weeks, some will have symptoms for months or longer. Talk with your children's or teens' healthcare provider if their concussion symptoms do not go away, or if they get worse after they return to their regular activities.

What Are Some More Serious Danger Signs to Look Out For?

In rare cases, a dangerous collection of blood (hematoma) may form on the brain after a bump, blow, or jolt to the head or body, and can squeeze the brain against the skull. Call 9-1-1 or take your child or teen to the emergency department right away if, after a bump, blow, or jolt to the head or body, he or she has one or more of these danger signs:

- One pupil larger than the other
- Drowsiness or inability to wake up
- A headache that gets worse and does not go away
- Slurred speech, weakness, numbness, or decreased coordination
- Repeated vomiting or nausea, convulsions or seizures (shaking or twitching)
- Unusual behavior, increased confusion, restlessness, or agitation
- Loss of consciousness (passed out/knocked out). Even a brief loss of consciousness should be taken seriously

Children and teens who continue to play while having concussion symptoms, or who return to play too soon—while the brain is still healing—have a greater chance of getting another concussion. A repeat concussion that occurs while the brain is still healing from the first injury can be very serious, and can affect a child or teen for a lifetime. It can even be fatal.

What Should I Do If My Child or Teen Has a Possible Concussion?

As a parent, if you think your child or teen may have a concussion, you should:

1. Remove your child or teen from play.
2. Keep your child or teen out of play the day of the injury. Your child or teen should be seen by a healthcare provider and only return to play with permission from a healthcare provider who is experienced in evaluating for concussion.
3. Ask your child's or teen's healthcare provider for written instructions on helping your child or teen return to school. You can give the instructions to your child's or teen's school nurse and teacher(s) and return-to-play instructions to the coach and/or athletic trainer.

Do not try to judge the severity of the injury yourself. Only a healthcare provider should assess a child or teen for a possible concussion. Concussion signs and symptoms often show up soon after the injury. But you may not know how serious the concussion is at first, and some symptoms may not show up for hours or days.

The brain needs time to heal after a concussion. A child's or teen's return to school and sports should be a gradual process that is carefully managed and monitored by a healthcare provider.

To learn more, go to cdc.gov/HEADSUP

Discuss the risks of concussion and other serious brain injuries with your child or teen, and have each person sign below.

Detach the section below, and keep this information sheet to use at your children's or teens' games and practices to help protect them from concussion or other serious brain injuries.

☐ I learned about concussion and talked with my parent or coach about what to do if I have a concussion or other serious brain injury.

  Athlete's Name Printed: __________________________________________ Date: __________
  Athlete's Signature: __________________________________________

☐ I have read this fact sheet for parents on concussion with my child or teen, and talked about what to do if they have a concussion or other serious brain injury.

  Parent or Legal Guardian's Name Printed: __________________________ Date: __________
  Parent or Legal Guardian's Signature: __________________________

Revised January 2019
The Grosse Pointe Academy
Asthma Action Plan (AAP)

Student’s Name ____________________________
Date of birth _______ Age _______ Grade _______ Teacher ________________________

Call First (Parent/Guardian):
Name: ___________________ Relationship: ___________________ 
Home #: ___________________ Cell: ___________________ Work #: ___________________

Try Second (Parent/Guardian):
Name: ___________________ Relationship: ___________________ 
Home #: ___________________ Cell: ___________________ Work #: ___________________

IMPORTANT: If prescribed an inhaler there must be two (2) inhalers provided to the school.
Parent/Guardian Signature: ___________________ Date: __________

The following is to be completed by the PHYSICIAN:

1. Asthma severity (circle one): mild intermediate - mild persistent - moderate persistent - severe persistent
2. Medications (at school AND home):

<table>
<thead>
<tr>
<th>A. QUICK-RELIEF Medication Name</th>
<th>MDI, Oral, Nebulizer?</th>
<th>Dosage or Number of Puffs</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B. ROUTINE Medication Name (e.g., anti-inflammatory)</th>
<th>MDI, Oral, Nebulizer?</th>
<th>Dosage or Number of Puffs Time of day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>C. BEFORE PE, EXERTION Medication Name</th>
<th>MDI, Oral, Nebulizer?</th>
<th>Dosage or Number of Puffs</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. Check Known Triggers:
- Animals
- Air Pollution
- Cold Weather
- Dust Mites
- Exercise
- Food
- Mold
- Pesticides
- Respiratory Infection
- Smoke
- Strong Odors
- Other: ___________________

4. Please check correct option:
- □ I have instructed this child in the proper way to use his/her inhaled medications. It is my professional opinion that this child should be allowed to carry and use that medication by him/herself.
- □ It is my professional opinion that this child should not carry and use that medication by him/herself.

5. Peak Flow: Write patient's personal best peak flow reading under the Green Zone box (below).

<table>
<thead>
<tr>
<th>Green Zone</th>
<th>Yellow Zone</th>
<th>Red Zone</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Symptoms</td>
<td>Starting to cough, wheeze, chest tightness, or shortness of breath. Can do some, but not all, usual activities.</td>
<td>Not responding to quick relief medication - Cough, short of breath, trouble walking or talking, nasal flaring, chest and neck pulls in with breathing, stooped body posture, lips or finger nails are grey or blue.</td>
</tr>
<tr>
<td></td>
<td>Give quick-relief medication.</td>
<td>Call 911 and begin emergency plan.</td>
</tr>
<tr>
<td></td>
<td>Personal Best Peak flow:_________</td>
<td>Peak flow from _________ to _________</td>
</tr>
<tr>
<td></td>
<td>Peak flow from _________ to _________</td>
<td>Peak flow from _________ to _________</td>
</tr>
</tbody>
</table>

School Emergency Plan:
If student has: a) no improvement 15-20 minutes AFTER initial treatment with quick-relief medication, b) peak flow of < 50% of usual best, c) trouble walking, or talking, or d) chest/neck muscle retractions with breathes, hunched, or blue color, then: 1) Give quick-relief med(s); repeat in 20 minutes, if help has not arrived; 2) Seek emergency care (911); 3) Contact parents.

Physician’s Name* (print): ___________________ Signature: ___________________ Date: __________
Office Address: ___________________ Office Telephone: ___________________

*Includes nurse practitioner or other health care provider as long as there is authority to prescribe.
**FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN**

Name: ____________________________ D.O.B.: ____________________________

Allergy to: ____________________________

Weight: ____________ lbs. Asthma: □ Yes (higher risk for a severe reaction) □ No

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following allergens: ____________________________

THEREFORE:

□ If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.

□ If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.

FOR ANY OF THE FOLLOWING:

**SEVERE SYMPTOMS**

- **LUNG**
  - Shortness of breath, wheezing, repetitive cough

- **HEART**
  - Pale or bluish skin, faintness, weak pulse, dizziness

- **THROAT**
  - Tight or hoarse throat, trouble breathing or swallowing

- **MOUTH**
  - Significant swelling of the tongue or lips

- **SKIN**
  - Many hives over body, widespread redness

- **GUT**
  - Repetitive vomiting, severe diarrhea

- **OTHER**
  - Feeling something bad is about to happen, anxiety, confusion

1. **INJECT EPINEPHRINE IMMEDIATELY.**

2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.
   - Consider giving additional medications following epinephrine:
     - Antihistamine
     - Inhaler (bronchodilator) if wheezing
   - Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
   - If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
   - Alert emergency contacts.
   - Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

FOR MILD SYMPTOMS FROM MORE THAN ONE SYSTEM AREA, GIVE EPINEPHRINE.

FOR MILD SYMPTOMS FROM A SINGLE SYSTEM AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

**MEDICATIONS/DOSES**

Epinephrine Brand or Generic: ____________________________

Epinephrine Dose: □ 0.1 mg IM □ 0.15 mg IM □ 0.3 mg IM

Antihistamine Brand or Generic: ____________________________

Antihistamine Dose: ____________________________

Other (e.g., inhaler-bronchodilator if wheezing): ____________________________

**PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE**

**DATE**

**PHYSICIAN/HCP AUTHORIZATION SIGNATURE**

**DATE**

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) | FOODALLERGY.ORG 5/2018
FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO
1. Remove Auvi-Q from the outer case.
2. Pull off red safety guard.
3. Place black end of Auvi-Q against the middle of the outer thigh.
4. Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.
5. Call 911 and get emergency medical help right away.

HOW TO USE EPIPEN® AND EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN
1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
5. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
6. Remove and massage the injection area for 10 seconds.
7. Call 911 and get emergency medical help right away.

HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), USP AUTO-INJECTOR, IMPAX LABORATORIES
1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps; you will now see a red tip.
3. Grasp the auto-injector in your fist with the red tip pointing downward.
4. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh.
5. Press down hard and hold firmly against the thigh for approximately 10 seconds.
6. Remove and massage the area for 10 seconds.
7. Call 911 and get emergency medical help right away.

HOW TO USE TEVA'S GENERIC EPIPEN® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR, TEVA PHARMACEUTICAL INDUSTRIES
1. Quickly twist the yellow or green cap off of the auto-injector in the direction of the "twist arrow" to remove it.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, pull off the blue safety release.
4. Place the orange tip against the middle of the outer thigh (upper leg) at a right angle (perpendicular) to the thigh.
5. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
6. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
7. Remove and massage the injection area for 10 seconds.
8. Call 911 and get emergency medical help right away.

ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:
1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outter thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

EMERGENCY CONTACTS — CALL 911

RESUE SQUAD: __________________________ PHONE: __________________________
DOCTOR: __________________________ PHONE: __________________________
PARENT/GUARDIAN: __________________________ PHONE: __________________________

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: __________________________ PHONE: __________________________
NAME/RELATIONSHIP: __________________________ PHONE: __________________________
NAME/RELATIONSHIP: __________________________ PHONE: __________________________

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 1/2019