MORA INDEPENDENT SCHOOLS

NURSE'S OFFICE
SHANTEL GARCIA, RN, SCHOOL NURSE
BERNA TRUJILLO, SECRETARY/HEALTH ASSISTANT
P.O. BOX 179 MORA, NEW MEXICO 87732
TELE: 575-387-3112-3113 Fax: 575-387-3160

Dear Parents/Guardians:

I would like to take this time to welcome your child to the Mora Independent School District for the 2020-2021 school year.

In order to ensure a healthy environment for your child you are required to complete all sections of the attached forms (Emergency Notification, Health History, and Medication Consent). These forms are lengthy; however, they are important in the event that your child becomes ill or is involved in an accident during school hours or on school sponsored activities. Further, the form assists us in identifying any routine health care your child may need.

If your child is on medication that requires administration in the school, either on a regular basis or for emergency, you must request and complete a medication authorization form. The form needs to be signed by your child health care provider and submitted to the nurse's office.

The Mora School District will be providing the following over the counter medications for students: Acetaminophen (Tylenol), Ibuprofen (Motrin) and Throat Lozenges (Cough drops) with signed consent.

The Nurse's Office will continue to be located on the side of administration building to offer routine school nursing services.

We will provide COVID-19 Guidelines once NM PED Guidelines are released.

If you have any questions or concerns, please feel free to contact us at the nurse's office at 575-387-3112 or 575-387-3113.

Sincerely,

Shantel Garcia, RN

Shantel Garcia, RN
MISD Nurse

Berna Trujillo
Secretary/Health Assistant

MORA INDEPENDENT SCHOOL DISTRICT

Student Health History & Emergency Medical Treatment Consent Form School Year _____

Student		School	Grade/Teacher
Address		Birth Date	Gender
Parent/Guardian/Emergency Contacts	**Relationship**	**☎ Phone**	
Call 1st:		Home: Work:	Cell:
Call 2nd:		Home: Work:	Cell:
Call 3rd:		Home: Work:	Cell:

Student's doctor/healthcare provider: _____ **Phone:** _____

Insurance Information: _____

(Include Group's Name, ID Number, Group Number, and Subscriber)

INDICATE IF STUDENT HAS BEEN DIAGNOSED BY A LICENSED HEALTHCARE PROVIDER WITH ANY OF THE FOLLOWING:

If your child has a life-threatening condition, state law requires that medication and/or treatment orders from your licensed healthcare provider, and an Emergency Plan prepared by the School Nurse, must be in place before your child can attend school.

Health Condition	Yes	No	Explanation if "Yes"
Medication Allergies	☐	☐	List:
Food Allergies	☐	☐	Food(s): ☐ peanut ☐ dairy ☐eggs ☐other _____ Rate the reaction: ☐mild ☐moderate ☐ life-threatening Does your child require an EpiPen? ☐yes ☐no
Allergy to Bees Stings	☐	☐	Rate the reaction: ☐mild ☐moderate ☐ life-threatening Does your child require an EpiPen? ☐yes ☐no
Allergies (other)	☐	☐	List:
Asthma	☐	☐	Rate the severity: ☐mild ☐moderate ☐ life-threatening Asthma medication taken at home: Medication required at school:
Diabetes	☐	☐	☐Type 1 (Insulin Dependent) ☐Type 2 Diabetes medication(s) taken at home:
Seizure Disorder	☐	☐	Type of Seizure: Medications:
Neurological Disorder	☐	☐	Specify:
Heart Condition	☐	☐	Specify:
Blood Disorder	☐	☐	Specify: Treatment:
Cancer	☐	☐	Specify: Treatment:
Bowel/Bladder Issues	☐	☐	Specify:
Migraine Headaches	☐	☐	Triggers: Treatment:

Bone/Muscle Problems	☐	☐	Specify: Activity Restrictions:
ADD/ADHD	☐	☐	Medication for ADD/ADHD:
Mental Health Behavioral Issues	☐	☐	Specify: Treatment/Medication:
Wears Glasses/Contacts	☐	☐	☐Glasses ☐Contacts → ☐For Distance ☐For Reading
Hearing Loss	☐	☐	☐Hearing Loss Right Ear ☐Hearing Loss Left Ear ☐Hearing Aid(s)
Other Serious Illness	☐	☐	Specify: Date of Onset:
Serious Injury	☐	☐	Specify: Date(s):
Surgery	☐	☐	Specify: Date(s):
Medication Taken at Home *(if not already listed)*	List:		

The information on this form may be shared confidentially with school staff and emergency responders as needed. In the event of a medical emergency with my child, I understand every effort will be made to inform me. If emergency care is needed, I authorize qualified professionals to provide assessment, diagnosis and any necessary emergency treatment. I understand that the school district assumes no financial liability for expenses incurred due to accident, injury and/or unforeseen circumstance.

_____ _____ _____

PARENT/GUARDIAN SIGNATURE *PRINTED NAME*

Reviewed by School Nurse: .....

Over-the-Counter (OTC) Consent Form

Child's name: _____ Age: _____

Child allergies: _____ Please help us keep your child safe by informing us of what you do not want your child to be given and include unmentioned medicines we should avoid.

MEDICINE NOT to be used (if not listed below): _____

Medication	Dosage according to the MRSD* label	Usage	Can be used?
Acetaminophen, Tylenol Reg. & Extra Strength	Reg. 250mg ES 500mg	Minor aches, pains, cramps, fever	Yes No
Ibuprofen, Advil, Motrin (NON-Aspirin)	1 or 2 tabs, 200mg	Minor aches, pains, fever	Yes No
Throat lozenges / cough drops	According to label	Sore throat	Yes No
Antihistamine, Benadryl topical & oral, Caladryl/Calamine lotion Sting/Bite wipes, Hydrocortisone	According to label	Stings, bites, colds, allergies, itch relief	Yes No
Burn gel	According to label	Burn relief	Yes No
Eye wash, contact lens solution		Irritation of the eye	Yes No
Hand sanitizer		Hand sanitation	Yes No
Neosporin foam, wound cleaner BZK towels, Triple antibiotic	Small dab to area	Wound cleaning treatment	Yes No
Petroleum jelly, lip balm		Dry skin, dry nose	Yes No

*Manufacturer's Recommended Starting Dose.

I give permission for my child (named above) to receive products listed on an as-needed basis. To the best of my knowledge, my child is not allergic to those mentioned. Unless otherwise directed, the medications will be administered as directed by package labeling.

Parent/caregiver signature: _____ Date: _____

Print name: _____ Phone # to reach adult: _____

Mora Independent Schools
Shantel Garcia, RN
Nurse's Office
P.O. Box 179
Mora, NM 87701

Dear Parents/Guardians:

Please keep your child home if he/she becomes ill and does not feel well enough to take part in school activities. This helps to prevent the spread of the illness to others at school. These are some of the examples of when your child should be kept home:

- Active vomiting
- Active diarrhea – three or more times in six hours
- The beginning of an airway infection (cold/cough/runny nose) [This is especially important for those who are unable to manage their own body fluids]
- Fever with headache, body aches, earache, sore throat
- Undiagnosed or unknown rash (a rash that has not been seen or treated by a health care provider)
- Any of the above symptoms with fever or chills
- Untreated skin conditions
- If antibiotic treatment is needed, your child should remain home for the first full 24 hours of medication (e.g., if your child has three doses per day ordered, then three doses must be given before the child returns to school)

If you have any question, please contact me at 575-387-3112 or 575-387-3113.

Thank You,

Shantel Garcia, RN
Shantel Garcia, RN
MISD Nurse