OFFICE OF SCHOOL NURSE
7280 Frenchman's Bay
St. Thomas, VI 00802
340-776-1600 x 4603
FAX: 340-776-1019
nurse@antilles.vi

2020-2021

EMERGENCY HEALTH INFORMATION FORM

Information on this form will be shared with school personnel directly involved with your child's education, unless you indicate otherwise.

Student's Last Name: _____ First Name: _____ Middle: _____

Student Usually Called _____

Grade: _____ Date of Birth: _____ Age: _____ Sex: _____

Home Address: _____ Home Phone: _____

Family Physician Name: _____ Physician's Phone: _____

Family Dentist's Name: _____ Dentist's Phone: _____

Emergency Contacts:

First Contact Parent/Guardian:	**Second Contact Parent/Guardian:**
Name: _____	_____
Employer: _____	_____
Daytime Phone: _____	_____
Cell Phone: _____	_____
Email: _____	_____

In case of emergency, if a parent/guardian cannot be reached, notify:

1. _____ Phone: _____

2. _____ Phone: _____

ALLERGIES: Please list ALL allergies including food and drug:

_____

_____

_____

If your child has a health condition(s), which may require EMERGENCY ACTION while at school (e.g., seizures, insect sting allergy, asthma, bleeding condition, sickle cell, diabetes, heart condition, peanut allergy, other), please use the space below to provide detailed information.

_____

_____

_____

_____

_____

Continue on back. Thank you for completing.

Antilles School attempts to discourage distribution of medication while students are at the school. If your physician determines it is necessary for your child to receive prescription medication during the hours your child is in attendance at Antilles, the specific directions and approval accompanied by physician's signature must be provided on the Medication Release Form prior to dispensing of any prescription medication. For your child's safety, it is recommended that first dosage of any medication be administered with the physician or at home.

Please send all medication(s) to the Antilles School Nurse in its original box or bottle with a current prescription label on the container. Pharmacists will assist when necessary to provide a "duplicate" container for this purpose.

_____

2020-2021 School Year

Student's Last Name: _____ First Name: _____ Middle: _____

I/WE hereby grant my/our express permission for the Antilles School Nurse or other School Personnel to administer non-prescription, over-the-counter medication(s) on an as needed basis to my child during the school day for such common ailments as headache, menstrual cramps, fever, rash, etc. (All over-the-counter medications are age appropriate)

*Please check one of the following:

◯ YES, my child can have OTC medications at school (this includes bug spray and sunscreen).

◯ YES, my child can have OTC medications at school with the exception of the following: _____

_____

◯ NO, my child cannot have OTC medications at school.

◯ NO, my child cannot have OTC medications at school, with the exception of hurt-free antiseptic wash and triple antibiotic ointment for cuts in the event of an injury at school.

_____

In the event that I/We am/are unable to be contacted during an emergency situation for my/our child, I/We hereby give my/our express permission for Antilles School to admit my child for emergency treatment to the hospital or other medical facility. I also give Antilles School Nurse or other School Personnel permission to administer Emergency Epinephrine in the form of an Auto-Injector Pen in an allergic emergency/anaphylaxis.

*Please check one of the following:

◯ YES

◯ NO

Parent/Guardian Signature Date Parent/Guardian Signature Date

_____ _____ _____ _____

Universal Child Health Record

Endorsed by the Virgin Islands Department of Human Services

CTION 1 TO BE COMPLETED BY PARENT{S) /GUARDIAN		
Child's Name (Last) (First)	Gender (O Male O Female	Date of Birth / /
Does the child have health insurance (O Yes O No	If yes, Name of Child's Health Insurance Carrier	
Parent / Guardian Name	Home Telephone Number	Work Telephone or Cell Phone Number
Parent / Guardian Name	Home Telephone Number	Work Telephone or Cell Phone Number
I give consent for my child's Health Care Provider & Child Care Provider/School Nurse to discuss information on this form.		
Signature / Date	his form may be release to the V.I. DeRartment of Human Services (O Yes O No	

SECTION 2 - TO BE COMPLETED BY HEALTH CARE PROVIDER

IMMUNIZATION ( ) Immunization Record Attached ( ) All recommended immunizations are up to date.

( ) A catch-up schedule for immunizations has been initiated

Vaccine	("}If Vaccine Series is Completed	If NOT Completed,Date of Next Dose Due
Dtap		
Hepatitis A		
Hepatitis B		
Hib		
Influenza		
MMR		
Polio		
Prevnar		
Rotavirus		
Varicella		

Date of PhysicalExamination: Results of physicalexamination normal? ( ) Yes ()No

Height: Weight:

Abnormalities Noted:

MEDICAL CONDITIONS		
Chronic MedicalConditions/Related Surgeries *List medical conditions & ongoing surgical concerns	( ) None ( ) Special Care Plan Attached	Comments:
Medications/Treatments *List medications/treatments	( ) None ( ) Special Care Plan Attached	Comments:
Limitations to Physical Activity *List limitations/specialconsiderations	( ) None ( ) Special Care Plan Attached	Comments:
SpecialEquipment Needs *List items needed for daily activities	( ) None ( ) Special Care Plan Attached	Comments:
Allergies/Sensitivities *List allergies	( ) None ( ) Special Care Plan Attached	Comments:
Special Diet *List dietary specifications	( ) None ( ) SpecialCare Plan Attached	Comments:
Behavioral Issues/Mental Health Concerns *List behavioral/mentalhealth issues	( ) None ( ) SpecialCare Plan Attached	Comments:
Emergency Plans *List emergency plan that might be need and the signs/symptoms to watch for:	( ) None ( ) SpecialCare Plan Attached	Comments:

( ) I have exammed the ch1ld hsted above & rev1ewed h1s/her health h1story. It IS my op1mon that he/she 1s med1cally cleared to participate fully in all child care/schoolactivities, including physical education & competitive contact sports, unless noted above.

A copy of the child's Immunization Record must be attached and the Physician completing this form must print and sign name below

Address of Health Care Provider	Phone Number of Health Care Provider
Physician Name: (Please Print)	Physician Name: (Signature) Date:

Distribution: Original - Child Care Provider Yellow Copy- Parent/Guardian Pink Copy - Health Care Provider

VIIR

STUDENT'S IMMUNIZATION DATA FORM

Name of Facility: Antilles School

Reporting Period: 2020-2021

Please **PRINT CLEARLY**, fill out **ALL** of the **REQUIRED DATA** and attach a **COPY** of the student's immunization card. *(If single birth use "1", if multiple birth (twin triplet, etc) use "1" for first born, "2" for second born, etc)*

Birth Status: __ of __

Child's First Name: _____ Middle Init: ____ Child's Last Name: _____

Gender: ☐ Male ☐ Female Home Telephone Number: _____

Date of Birth: _____ Age: _____ Soc. Sec. No.: _____

Physical Address: _____ City: _____ Zip Code: _____

Mailing Address: _____ City: _____ Zip Code: _____

Race: ☐ White ☐ Black ☐ Other (please specify): _____

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Mother's First Name: _____ Mother's **Maiden** Last Name: _____

Work Telephone Number: _____

Father's First Name: _____ Father's Last Name: _____

Work Telephone Number: _____

I agree and understand that my child's immunization information will be entered in the VIIR and may be shared with schools, daycares, health care providers, and any other health care professionals as necessary to verify immunization status and public health studies.

_____ _____ _____

Parent/Guardian (Please Print) Parent/Guardian Signature Relationship

_____

Date

Antilles SCHOOL
Excellence Diversity Community

OFFICE OF SCHOOL NURSE
7280 Frenchman's Bay
St. Thomas, VI 00802
340-776-1600 x 4603
FAX: 340-776-1019
nurse@antilles.vi

2020-2021

AFTER SCHOOL ACTIVITIES MEDICAL CERTIFICATION

St. Thomas/St. John Interscholastic Athletic Association and Physician Consent

PHYSICIAN CONSENT

This is to certify that I am a licensed physician and that I have examined _____ age _____. I consider the above student physically able to participate in organized, competitive athletic activities for the school year **2020-2021** in any sport NOT CROSSED OUT below.

Swimming	Tennis	Flag Football	Tackle Football
Volleyball	Sailing	Track & Field	Basketball
Weight Lifting	Softball	Cross-country	Soccer
Baseball	Yoga	Wrestling	Gymnastics
Martial Arts	Dance	Push Fitness Camp	other _____

_____ _____
Physician's Signature Date

_____ _____
Physician's Address Telephone

PARENT CONSENT

This is to certify that I am the Parent/Guardian of _____ who was born on _____ and is enrolled in Antilles School. As Parent/Guardian, I give express permission for the above named student to participate in organized, competitive athletic activities from 2020-2021, and in any and all sports activities in which the student is medically certified and able to participate. The student may travel with any school team of which the student is a member. Furthermore, I authorize the school to obtain any emergency medical care that may become reasonably necessary for the student in the course of such athletic activities or travel.

I acknowledge that such activities have an inherent risk of injury, regardless of the sport, and that on rare occasions, injuries may be severe, and in extreme cases may even result in death.

I have read and understand the above statements.

_____ _____
Parent/Guardian Signature Date

_____ _____
Parent/ Guardian Signature Telephone

OFFICE OF SCHOOL NURSE
7280 Frenchman's Bay
St. Thomas, VI 00802
340-776-1600 x 4603
FAX: 340-776-1019
nurse@antilles.vi

2020-2021

PRESCRIPTION (RX) MEDICATION RELEASE FORM

Dear Parents/Guardians,

Antilles School discourages dispensing medication to students during the school day. However, if your physician determines it is necessary for your child to receive prescription medication during the hours your child is in attendance at Antilles, specific directions and approval accompanied by physician's signature must be provided to Antilles School prior to dispensing of any prescription medication at school. For the safety of all children, no prescription medication will be dispensed or permitted at Antilles School without detailed directions and specific physician's approval for such distribution. For your child's safety, it is strongly recommended that initial dose(s) of any medication is administered with the physician or at home.

If a child must take medication during the school day, the Parent/Guardian must do the following:

1. Physician must provide specific, written instructions for administering any and all prescription medication(s) for your child to Antilles School prior to dispensation of first dosage scheduled during the time child is in attendance at Antilles School.
2. Take this form to your family physician to record instructions for dispensing medication to your child along with physician's signature of approval.
3. Parent/Guardian must deliver any and all medication(s) prescribed for their child/children to the Antilles School nurse or school personnel along with this form completed by physician prior to dispensation of first dosage scheduled during the time child is in attendance at Antilles School.
4. Any and all medication must be in the original box or container with the current prescription label. Upon request, pharmacists will provide a "duplicate" container for this purpose.

Student's Last Name	First	Middle	Usually Called

Current Grade	Date of Birth	Age	Sex

Home Address	Home Telephone Number	Cellular Phone Number

Parent/Guardian Signature	Date	Parent/Guardian Signature	Date

Physician's Directions for Dispensation of Prescription Medication:

Family Physician's Name (PLEASE PRINT)	Physician's Telephone Number

Family Physician's Signature	Date