LKC Contact Information

Child's Name: _____ Grade: _____

Legacy Traditional Campus Attending in 2017/2018: _____

Parent or Guardian Name: _____

Telephone Numbers: Cell _____ Home _____

Work _____

Home Address: _____

Parent or Guardian Name: _____

Telephone Numbers: Cell _____ Home _____

Work _____

Home Address: _____

Additional Emergency Contacts:

Name: _____

Telephone Numbers: Cell/Home _____ Work _____

Name: _____

Telephone Numbers: Cell/Home _____ Work _____

Persons Authorized for Pickup /Drop off:

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

Legacy KIDS CARE
Before and After School Program

CERTIFICATE OF GOOD HEALTH

Child's Name: _____ Date of Birth _____

Is your child having any of the problems listed below? *	**YES**	**NO**
1. Allergies or reactions (for example, food, medication, or other) 2. If yes: please list:		
2. Hay Fever		
3. Asthma		
4. Eczema or frequent skin rashes		
5. Convulsions/Seizures		
6. Heart Trouble		
7. Diabetes		
8. Frequent colds, sore throats, earaches (4 or more per year)		
9. Trouble passing urine or bowel movements		
10. Shortness of breath		
11. Speech problems		
12. Other		
Please explain any problem identified above: * Additional paperwork may be required including a medical action plan signed by child's physician before care can begin.		
Does your child take any medications regularly? If yes, what medication?		
Reason for Medication:		

I hereby certify that my child is in good health and that his/her immunizations are current. I will assume responsibility for my child's health while atLKC.

Signature of Parent of Guardian: _____ Date: _____

Child's Name: _____ Age: _____

STUDENT RECORD REQUEST RELEASE

INFORMATION TO BE RELEASED FROM:	INFORMATION TO BE RELEASED TO:
Name: **Legacy Traditional Schools**	Name: **Legacy Kids Care (LKC) –** Please list campus name
School:	Title: **Admin and Staff**
Street Address:	Street Address:
City/State/Zip:	City/State/Zip:
Phone Number: Fax:	Phone Number:

Parent/Guardian would like the following records and/or information released to Legacy Kids Care (LKC):

_____ Health & Immunization Records

_____Psychological Evaluation Records

_____ Special Education Records

_____ Section 504 Plan Records

_____ Verbal Communication

_____ Written Communication

_____ Other: _____

Student Name	Date of Birth	Grade

I hereby authorize the school named above to release information, both verbally and in writing, to Legacy Kids Care (LKC).

_____ _____

Signature of Parent/Guardian Date

_____ _____

Signature of LKC Official Date

Administering Medication to Students at Legacy KidsCare

Name_____ Date_____

Teacher_____ School_____ Grade_____

Medication_____Dosage_____

Diagnosis/Reason for Giving_____

Time to be given_____AM_____PM

Dates:_____ To_____

Prescription medication must be in the original container as prepared by a pharmacist and labeled, including the patient's name, name of medication, dosage, and time to be given. An over-the-counter medication must be in the original packaging with all directions, dosages, compound contents, and proportions clearly marked. Student misuse of medication being self-administered may result in seizure and disciplinary action.

_____ _____

Parent/Guardian Signature Date

*A new form is required for any change in medication name or dosage and at the beginning of each summer.

***Staff members in charge of the Legacy KidsCare will assist students, as trained by the parent, following a physician's order. Parent initials _____.**

******Over the counter medication is not given.**

Permit for Self-Administration of Emergency Epinephrine for _____Legacy KidsCare

Student_____School_____DOB_____Grade____

Legal Reference: ARS 15-341 (2005) allows students who have been diagnosed with anaphylaxis by a healthcare provider to carry and self-administer emergency medications including auto-injectable epinephrine while at school and at school sponsored activities. The student's name on the prescription label on the medication container or on the medication device is sufficient proof that the pupil is entitled to the possession and self-administration of the medication. The statute also provides immunity from civil liability for a school district and its employees with respect to all decisions made and actions taken that are based on good faith implementation of the requirements of this paragraph, except in cases of wanton or willful neglect.

Name of medication_____

Dosage_____ Expiration Date_____

I hereby give permission for my child to carry the above listed medication as ordered by his/her licensed healthcare provider. I understand that my child, not the school, is responsible for the storage, possession, and use of the self-administered medication. I understand that misusing medication or sharing medication with other students will result in disciplinary action. I agree to deliver the medication to the school health office with an appropriate pharmacy prescription label and to provide the health office with a back-up medication. I understand that it is the responsibility of my child to report to the Health Office or other staff member if symptoms do not improve after taking this medication.

"Self-Administration" means that my child has the discretion to use his/her medication appropriately. Therefore as parent/guardian, I acknowledge that my child is capable of identifying the medication, is knowledgeable of the purpose of the medication, is able to identify/associate specific occurrence and need for the administration of the medication, is knowledgeable/capable of medication dosage, is knowledgeable/capable of administrative method, is able to state side effects/adverse reactions to the medication, and is knowledgeable of how to access assistance for self if needed in an emergency.

I acknowledge that Athlos Traditional Academy/Legacy Traditional Schools and its employees will be immune from civil liability for all decisions made and actions taken in good faith to implement these provisions per ARS 15-341 and ARS 15-344. I also acknowledge that Athlos Traditional Academy/Legacy Traditional Schools and its employees will be exempt from civil liability as a result of any injury arising from my child's self-administration and/or misuse of the medication.

Parent/Guardian Name_____

Parent/Guardian Signature_____Date_____

Prescribing Physician Name_____Ph. Number_____

I have read the above and understand my responsibility to carry and self-administer my medication and will notify the Health Office or other staff member if my symptoms do not improve after taking this medication.

Student Signature_____Date_____

☐ (Office Use) Check if Emergency Action Plan is complete and on file

Permit for Self-Administration of Inhaler Medication for _____ Legacy KidsCare

Student_____School_____ DOB_____ Grade_____

Legal Reference: ARS 15-341 (2005) allows the possession and self-administration of prescription medication for breathing disorders in handheld inhaler devices by students who have been prescribed the medication by a licensed health care professional. The student's name on the prescription label on the medication container or on the medication device is sufficient proof that the pupil is entitled to the possession and self-administration of the medication. The statute also provides immunity from civil liability for a school district and its employees with respect to all decisions made and actions taken that are based on good faith implementation of the requirements of this paragraph, except in cases of wanton or willful neglect.

Name of medication_____

Dosage_____ Expiration Date_____

I hereby give permission for my child to carry the above listed inhaler as ordered by his/her licensed health care provider. I understand that my child, not the school, is responsible for the storage, possession, and use of the self-administered inhaler. I understand that misusing medication or sharing medication with other students will result in disciplinary action. I agree to deliver the medication to the school health office with an appropriate pharmacy prescription label and to provide the health office with a back-up medication. I understand that it is the responsibility of my child to report to the Health Office or other staff member if symptoms do not improve after taking this medication.

"Self-Administration" means that my child has the discretion to use his/her medication appropriately. Therefore as parent/guardian, I acknowledge that my child is capable of identifying the medication, is knowledgeable of the purpose of the medication, is able to identify/associate specific occurrence and need for the administration of the medication, is knowledgeable/capable of medication dosage, is knowledgeable/capable of administrative method, is able to state side effects/adverse reactions to the medication, and is knowledgeable of how to access assistance for self if needed in an emergency.

I acknowledge that Athlos Traditional Academy/Legacy Traditional Schools and its employees will be immune from civil liability for all decisions made and actions taken in good faith to implement these provisions per ARS 15-341 and ARS 15-344. I also acknowledge that Athlos Traditional Academy/Legacy Traditional Schools and its employees will be exempt from civil liability as a result of any injury arising from my child's self-administration and/or misuse of the medication.

Parent/Guardian Name_____

Parent/Guardian Signature_____Date_____

Prescribing Physician Name_____Ph. Number_____

I have read the above and understand my responsibility to carry and self-administer my inhaler and will notify the Health Office or other staff member if my symptoms do not improve after taking this medication.

Student Signature_____Date_____

☐ (Office Use) Check if Asthma Action Plan is complete and on file