SAN CARLOS UNIFIED SCHOOL DISTRICT NO. 20

We exit to educate and empower students to become culturally responsive, global Nn' ee.

HEALTH OFFICE INFORMATION - SY2026-2027

The Health Office Staff welcomes new and returning students to San Carlos Unified School District. To assist in providing the quality care your student deserves, please COMPLETE this packet and return to health office staff at your student's school.

Student Name_____Grade:_____Date of Birth_____

Parent/Guardian_____

Phone: Home_____ Cell: _____ Work: _____

Mailing Address: _____

Physical Address_____

Emergency Contacts:

Nurse will contact adults listed on the Enrollment packet, these adults need to be aware that they are listed on your child's emergency contact therefore a good telephone number should be kept updated with each site per student.

Phone number (928) 475-2315

Rice Primary Ex. 2001

Rice Intermediate Ex. 3001

SC Middle School Ex. 4001

SC High School Ex. 5001

SC Alternative Ex. 5001

San Carlos Unified School District No 20

We exist to educate and empower students to become culturally responsive, global Nn'ee.

JLCC © - COMMUNICABLE / INFECTIOUS DISEASES

Any student with, or recovering from, a communicable disease will not be permitted in school until the period of contagion is passed or until a physician recommends a return, in accordance with A.R.S. 36-621 *et seq*., appropriate regulations of the State Department of Health Services, and policies of the County Health Department.

Parents will be requested to provide a history of the communicable diseases for each student, and such records will be kept and maintained by the District.

A student suffering from a communicable disease shall be excluded from school to protect the student's own welfare and also to protect other students from illness. Early recognition of a communicable disease is of prime importance. The administrator or county health director shall make the decision for exclusion and readmission.

Pediculosis (Lice Infestation)

Students with pediculosis shall be excluded from school until treated with a pediculicide.

Adopted: June 13, 2017

I confirm that I have read, understand and agree to the above policy and procedure for enrollment in the San Carolus Unified School District No 20.

_____ _____

Parent/Guardian Name – Please Print Student Name Grade

_____ _____

Parent/Guardian Signature Date

Our Vision Statement- We will become an effective student focused learning community graduating culturally confident citizens.

P.O.BOX 207 ~San Carlos Avenue~San Carlos, Arizona 85550 Phone (928) 475-2315, Fax (928) 475-2301

Student Name: _____ Date of Birth: _____

San Carlos School District No. 20 Health Office Information

SY 2026-2027

Here at the San Carlos School District we try to provide a safe environment for the students and staff, often basic first aid is practiced to ensure the safety of our students and staff.

Arizona State Law prohibits us from treating any condition without written permission from the parents and/or guardians.

The health office staff will contact you in cases that require your child to be sent home.

Below is a list of over-the-counter medications that can be provided to your student in the event his/her symptoms deem it necessary:

Tylenol (acetaminophen) I
Ibuprofen
Diotame(Pepto Bismal)
Triple antibiotic ointment
Oral pain relief gel
Hand Lotion
Tums (antacid tablets)
Benadryl Cream (anti-itch)

Hydrocortisone cream (skin irritation)
Saline eye wash
Saline eye drops
Cough drops
Cough and Cold
PMS Relief
Medi-Lyte
Diamode

Bacitracin ointment (cuts/scratches)
Lice shampoo (individual basis)
Lip balm
Seasonal Allergy Medication
Vaseline (dry skin)
Sinus Decongestant
First Aid and Burn Cream

Information on past medical history/health concerns would be helpful in providing the best care for your child: Please indicate whether or not your student has experienced any of the following conditions:

Seasonal Allergies Yes___ No___	Heart Condition Yes___ No___	Seizures (Epilepsy) Yes___ No___	Chronic Ear Infections Yes___ No___	ADHD Yes___ No___
Autism Yes___ No___	Asthma** Inhaler? Yes___ No____	History of Chicken Pox Yes___ No___	Weakened Immune System Yes___ No___	List Allergy, Treatment needed* _____ _____

If you answered yes to any of the above conditions please explain:

_____

_____

DOES YOUR CHILD TAKE DAILY MEDICATIONS? YES_____ NO_____ If your child requires medication during school hours you must see the SCHOOL HEALTH OFFICE STAFF to sign a medication consent form; your child will not be given medication until the medication consent is signed. The medication must be delivered.to health office in the **ORIGINAL** Prescription Bottle with the student's name listed, the name of the medication and prescription doctors name. Governing Board Policy JLCD.

I: _____ give permission for health office staff to provide my student first aid care, VISION & HEARING screening, any medication listed above and/or call the local Emergency Medical Transport service in the event of an emergency during school hours.

Parent/Guardian signature: _____ Date: _____

Fill out only if your student uses an inhaler or epi-pen.

Asthma/Reactive Airway Disease

If your student has Asthma, it is recommended they have an inhaler at school (if prescribed). The Health Services offices have Albuterol nebulizer treatments available for students experiencing severe shortness of breath. School Health Personnel will attempt to contact you prior to administering Albuterol and update you on your student's condition after administration and if further medical services will be required.

By signing below you give SCUSD Health Services Personnel permission to administer Albuterol nebulizer treatment for your student with Asthma who is experiencing severe shortness of breath with dose determined by the student's weight.

Student Name: _____Date of Birth_____

Parent/Guardian Signature: _____ Date_____

Provider Signature: _____ Date_____

SEVERE FOOD and BEE ALLERGIES

If your student has Severe Food or Bee Allergies, it is recommended they have an Epi Pen at school (if prescribed). The Health Services offices have Epi Pens treatments available for students experiencing severe Allergic Reactions. School Health Personnel will attempt to contact you prior to administering Epi Pen and update you on your student's condition after administration. If an Epi Pen is administered to your student, EMS will be contacted to transport your student to the Emergency Room for evaluation and continued treatment.

By signing below you give SCUSD Health Services Personnel permission to administer Epi Pen for treatment for your student with Severe Allergic Reaction who is experiencing a Severe Allergic Reaction with dose determined by the student's weight.

Student is allergic to: _____

Student Name: _____ Date of Birth: _____

Parent/Guardian Signature: _____ Date: _____

Provider Signature: _____ Date: _____

SAN CARLOS UNIFIED SCHOOL DISTRICT

San Carlos, Arizona • P. O. Box 207, San Carlos, AZ 85550

Mission Statement - We exist to educate and empower students to become culturally responsive, global Nn'ee.

Vision Statement- We will become an effective student focused learning community graduating culturally confident citizens

HEARING EXAM PERMISSION FORM

DATE: _____

Dear Parent/Guardian: _____

If your son/daughter fails the school hearing screening, a more extensive hearing exam will need to be completed on-site with the audiology team. Many hearing losses today may be corrected before they become serious. While some individuals have a temporary hearing loss during a cold or other infection, it is important that the cause of such a temporary loss be determined and treated to protect the individual's future hearing.

Why is it important to have your child's hearing tested? Hearing is important for speech, language development, reading and learning. While a hearing screening can detect if your child needs further testing, a complete diagnostic evaluation will determine the full health/status of all the parts of each ear and whether intervention is necessary. Even if your child has passed a hearing screening previously, their hearing can change. Hearing loss is invisible and your child may appear to be distracted and not paying attention in class or at home.

The hearing test will consist of one or more of the following tests:

- Tympanometry: Screening of middle ear function to determine presence/absence of middle ear fluid and /or wax which could interfere with normal hearing.
- Otoacoustic Emissions (OAEs): An objective test that screen for an estimate of hearing sensitivity.
- Audiometry: In depth testing of hearing acuity.

It is important to your child's school success to have a professional evaluation completed following a failed school screening. If a problem is found and corrected, it may help your child do better in school.

Please complete the following portion and return this form to your child's school.

☐ I give permission

☐ I do not give permission

For my child to receive a full diagnostic hearing test during the 2026-2027 school year. I understand that hearing aids may be needed for my child and that there may need to be additional follow up appointments to be scheduled at the San Carlos Apache Healthcare Audiology department.

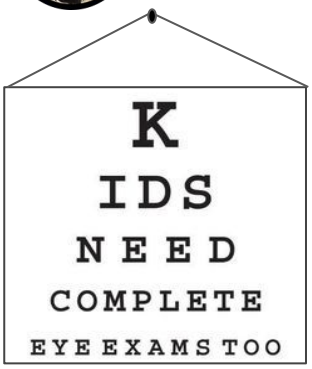
Childs Name: _____Date of Birth: _____

Signature of Parent/Guardian: _____

SAN CARLOS
Unified School District

Izeé Baa Gowąh
San Carlos Apache Healthcare

EYE EXAM PERMISSION FORM



Eye exams will be conducted at the school throughout the school year by an Optometrist from San Carlos Apache Healthcare.

Good vision is essential to your child's development, success in school, and overall well-being.

A comprehensive eye exam includes vision testing to assess if glasses are needed, evaluation of eye muscles, and overall eye health.

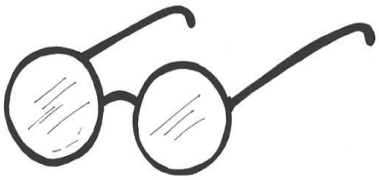
Dilation will **not** be done at this exam.

The visual system develops throughout childhood. It is critical to catch vision issues early to assure the visual system can fully develop. If a child's eyes cannot send clear images to the brain, his or her vision may become limited in ways that cannot be corrected later in life. The child may develop Amblyopia (lazy eye). If the brain can't interpret the image easily it will ignore that eye causing it to not develop fully.

Often times, children do not complain of not being able to see well, especially if their vision has always been poor. It is what is normal for them. If children are unable to see the board at school, they will have difficulty learning. Sometimes glasses are essential in helping a child succeed in school.

It is important if your child needs glasses to fill the prescription. Teach your child how to care for his or her glasses and keep them in good condition. Make sure they are wearing them, especially during school. If your child is having a hard time keeping track of their glasses arrangements can be made with their teacher to keep the glasses at school and available to the student.

Please note if your child has ACCHS or private insurance they will cover most or all of the cost of your child's glasses.



Please be sure your child brings their glasses to the exam if they already wear them.

Thank you for your participation in your child's eyecare!

Please complete the following portion and return this form to the school

☐ I give permission ☐ I do not give permission

For my child to receive an eye exam during the 2026-2027 school year. I understand that glasses may be needed for my child and that there may need to be additional follow-up appointments to be scheduled at San Carlos Apache Healthcare Optometry.

_____ _____

Child's Name Date of birth

_____ _____

Signature of parent or legal guardian Date

Izeé Baa Gowąh
San Carlos Apache Healthcare

Fluoride Varnish and Dental Sealant Permission Form

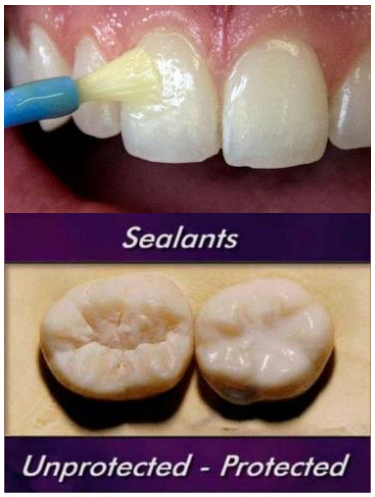
Dear Parent or Guardian,

Cavities can be prevented through brushing with toothpaste every day, having dental check-ups and the use of fluoride and dental sealants. With your permission, we will provide fluoride varnish and dental sealants to your child at their school this year and send home a letter informing you of any dental problems your child may have and how to help them.

Fluoride Varnish
Procedure: A high concentration fluoride varnish is brushed directly onto the teeth.
Benefits: Fluoride Varnish coats the outside of the tooth and strengthens enamel.

Dental Sealant
Procedure: The back teeth are washed and dried and then a plastic coating is painted on the grinding surface of the back teeth.
Benefits: Sealants prevent food, candy and acids from getting into the grooves of the teeth and causing a cavity

THERE ARE NO SHOTS, NO NUMBING, NO DRILLING, NO FIXING CAVITIES OR PULLING TEETH.



Dental Sealants help protect kid's teeth.

I give my permission for:

Student Name _____**Date of Birth**_____

Name of School_____ **Grade**_____**Teacher**_____

to be screened and have fluoride varnish and dental sealants placed on his or her teeth. I understand that this is a preventive program and the products are safe and effective and there will be no shots, numbing, drilling, fixing cavities or pulling any teeth.

Please list any physical conditions that the school should be aware of (asthma, allergies, recurring illnesses, Disabilities, chronic illnesses, etc.):_____

Parent or Guardian Name (print)_____

Signature_____ Date_____

Telephone Number_____Mailing Address_____

Thank you for your cooperation and your concern for your child's dental health.

Izeé Baa Gowąh
San Carlos Apache Healthcare

SCAHC/CWHC Screening and Consent Form for Child Influenza and Covid 19 Vaccination Injection

PATIENT NAME: _____ **DOB:** _____ **AGE:** _____

ADDRESS: _____ **PHONE:** _____ **CHART:** _____

SCHOOL NAME: _____ **PHONE:** _____

Answer the questions below to help us determine if there is any reason you should not receive the flu vaccine. If there are any questions, please let us know, and we can help you.

Must Be Completed

	INFLUENZA AND COVID SCREENING QUESTIONS	Yes	No
1	Are you sick today? (Fever) Temperature: _____ (temp will be taken at time of administration)		
2	Do you have severe allergies to EGGS, GELATIN, or LATEX?		
3	Have you ever had a serious reaction to any vaccine(s)?		
4	Are you taking medications that can lower your ability to fight infection(s)?		
5	Do you have a history of Guillain-Barre syndrome (GBS)?		
6	Have you read and reviewed the Vaccine Information Statement or Fact Sheet for the vaccine(s) listed below?		
7	Do you understand the risks and benefits of receiving the vaccine (s0 listed below and consent to receive the vaccine(s)?		
8	Do you want your Child to Receive the FLU vaccine during FLU season of 2026 (Oct 26- Mar 27)		
9	Do you want your Child to receive the COVID vaccine during Cold season of 2026 (Oct 26-Mar 27)		

Child Name: _____ **Date:** _____

Patient Signature: _____ **Date:** _____

I acknowledge that I understand the benefits and risks of the requested vaccination as described in the Vaccine Information Sheet, a copy of which is provided with this Consent and Release. I confirm San Carlos Apache Healthcare Corporation (SCAHC) or Clarence Wesley Health Center (CWHC), on behalf of its pharmacy in all divisions, has answered to my satisfaction all of my questions about the vaccine and the vaccination procedure. I request and consent that the vaccination be given, as I direct SCAHC/CWHC, either to me or the person named above, a minor for whom I represent that I am authorized to sign this Consent and Release. I understand that I am giving SCAHC/CWHC permission to release any medical or other information necessary to my physician, Medicare, Medicare HMO, or insurance company or immunization registry, as applicable, to enable SCAHC/CWHC to process my insurance claims with respect to the vaccination. I, for myself (and for the recipient of the vaccination, if the recipient is a minor), my heirs, executors and assigns hereby release SCAHC/CWHC and its divisions and affiliates and their respective officers, directors, employees, agents, and representatives from any and all claims arising out of our connection with the quality of the above-described vaccine(s) as provided by the manufacturer and any negligence of SCAHC/CWHC in connection with the related injection of the vaccination. I understand that the laws of my state may affect my remedies in connection with this vaccination. I understand that the laws of my state may affect my remedies in connection with this vaccination. Upon request by patient/guardian, a copy of recorded vaccination(s) record maybe obtained during this visit.

(For Internal Use Only)

Influenza Vaccine	Manufacturer	Lot Number	Expiration	Volume	Injection Site	VOS Date
COVID Vaccine	**Manufacturer**	**Lot Number**	**Expiration**	**Volume**	**Injection Site**	**VOS Date**

Vaccinator Signature: _____ **Vaccinator Title:** _____ **Date:** _____

Pharmacist Co-signer: _____ **(if applicable)**

Consent Form Updated:3/27/26

COVID-19 Vaccine:
What You Need to Know

Many vaccine information statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1. Why get vaccinated?

COVID-19 vaccine can prevent **COVID-19 disease**. Vaccination can help reduce the severity of COVID-19 disease if you get sick.

COVID-19 is caused by a coronavirus called SARS-CoV-2 that spreads easily from person to person. COVID-19 can be mild to moderate, lasting only a few days, or it can be severe, requiring hospitalization, intensive care, or a ventilator to help with breathing. COVID-19 can also result in death.

COVID-19 symptoms may appear 2 to 14 days after exposure to the virus. A person can have mild, moderate, or severe symptoms.

- Symptoms can include fever; chills; cough; shortness of breath or difficulty breathing; fatigue (tiredness); muscle or body aches; headache; new loss of taste or smell; sore throat; congestion or runny nose; nausea; vomiting; and diarrhea.
- More serious symptoms can include trouble breathing; persistent pain or pressure in the chest; new confusion; inability to wake or stay awake; and pale, gray, or blue-colored skin, lips, or nail beds (depending on skin tone).

Older adults and people of any age with certain underlying medical conditions (like heart or lung disease or diabetes) are more likely to get very sick with COVID-19.

After COVID-19 illness, some people get Long COVID, a chronic condition with symptoms lasting 3 months or longer. Symptoms of Long COVID may get better, get worse, or stay the same.

People who are up to date with COVID-19 vaccination have a lower risk of severe illness, hospitalization, and death from COVID-19 than people who are not up to date. COVID-19 vaccination is the best way to prevent Long COVID.

Getting a COVID-19 vaccine helps the body learn how to defend itself from the disease and reduces the risk for severe illness and complications. Additionally, COVID-19 vaccines can offer added protection to people who have already had COVID-19, including protection against being hospitalized if they become infected with COVID-19 again.

2. COVID-19 vaccine

Updated 2024–2025 COVID-19 vaccine is recommended for everyone 6 months of age and older. This includes women who are pregnant, breastfeeding, trying to get pregnant now, or who might become pregnant in the future.

2024–2025 COVID-19 vaccines for infants and children 6 months through 11 years of age are available under Emergency Use Authorization from the U. S. Food and Drug Administration (FDA). Please refer to the Fact Sheets for Recipients and Caregivers for more information.

For people 12 years of age and older, 2024–2025 COVID-19 vaccines, manufactured by ModernaTX, Inc. or Pfizer, Inc., are approved by FDA.

Novavax COVID-19 Vaccine Adjuvanted (2024–2025 Formula) vaccine is available under Emergency Use Authorization from FDA for people 12 years and older. Please refer to the Fact Sheet for Recipients and Caregivers for more information.

- **Everyone 6 months of age and older** is recommended to receive an age-appropriate FDA-approved or authorized updated 2024–2025 COVID-19 vaccine.
- **Certain people, such as those who have medical conditions or are taking medications that affect the immune system,** may need additional doses of COVID-19 vaccine. Your health care provider can advise you.

CDC U.S. CENTERS FOR DISEASE CONTROL AND PREVENTION