

**San Juan County School District #1
Health Information**

Student Name: _____

The following information is considered confidential and is for use by teachers, principals, school nurse/health staff, or other staff who will be in contact with and responsible for your child during the school day. If you prefer talking personally to the school nurse/health staff regarding any of the following statements, please mark here _____ and she will contact you.

CHECK ANY OF THESE CONDITIONS WHICH YOUR CHILD HAS:

- | | | | |
|--------------------|-----------------------------|---|-----------|
| ____ Cancer | ____ Kidney/Bladder Disease | ____ Vision Problems | ____ ADD |
| ____ Diabetes | ____ Convulsions, Seizures | ____ Hearing Problems | ____ ADHD |
| ____ Heart Disease | ____ Orthopedic/Bone | ____ Social/Emotional/Behavioral Concerns | |
| ____ Autism | ____ Bowel Concerns | ____ In Counseling | |

____ Allergy To: _____ Severe Yes ___ No ___

____ Asthma Provoked by _____ Severe Yes ___ No ___

____ Surgery Please List: _____

Has this student ever: Passed out during or after exercise? Yes ___ No ___

Had severe chest pain during or after exercise? Yes ___ No ___ Tire too easily, compared to friends? Yes ___ No ___

Been told they have a heart murmur? Yes ___ No ___

Felt palpitations of their heart or had skipped beats? Yes ___ No ___

Has anyone in their immediate family died of heart problems or died suddenly before age 50? Yes ___ No ___

Been denied participation in sports? Yes ___ No ___

Do you have medical insurance? Yes ___ No ___ What kind? _____

Has the above condition (s) been diagnosed by a medical doctor? Yes ___ No ___

If yes, what is the doctor's name? _____

May we obtain this information? Yes ___ No ___ If yes, please sign a release of information obtained from the school office.

What does the child do to manage their own condition? _____

How can the teacher help with this at school? _____

What symptoms should we report to you? _____

Takes Medication Daily at ___ Home ___ School

Medication is: _____

For: _____

IF YOUR CHILD MUST RECEIVE MEDICATION WHILE AT SCHOOL, A "PERMISSION FOR MEDICATION ADMINISTRATION AT SCHOOL" FORM MUST BE COMPLETED AND SIGNED BY THE ATTENDING PHYSICIAN AND PARENTS(S) OR LEGAL GUARDIAN(S) OF THE CHILD. YOU CAN OBTAIN THESE FROM THE SCHOOL OFFICE.

Please provide any information not included above which you think we should know about your child's physical, mental, or emotional health which might affect school performance or require special consideration (i.e. limitations in activities, etc.).

Parent/Guardian Signature _____ Date _____

San Juan County School District #1 Student Health and Emergency Information

Student _____ Date of Birth _____ Grade _____

Parent _____ Phone/Cell/Work Number _____

Name of Physician _____ Phone Number _____

Name of Dentist _____ Phone Number _____

Emergency Contact _____ Phone Number _____

Relationship _____

EMERGENCY CARE PERMIT

I, the undersigned, do hereby authorize officials of Silverton School District #1 to contact the persons on this form directly, and do authorize the named physician or dentist such treatment as may be deemed necessary in an emergency, for the health of said child. In the event your physician, other persons named on this form, or parents cannot be reached, the school officials are hereby authorized to take whatever action is deemed necessary in their judgment, for the health of said child. I will not hold the school district financially responsible for the emergency care or transportation for said child.

Parent/Guardian Signature

Date

SILVERTON CLINIC PERMISSION

I give permission for my child to be seen for a school/sports physical at the Silverton Clinic with the provider on staff.

Parent/Guardian Signature

Date

P.O. Box 128
1160 Snowden Street
Silverton, CO 81433
www.silvertonschool.org



Kim White, Superintendent
Phone: (970)387-5543
Fax: (970) 387-5791
supt@silvertonschool.org

PHYSICIAN'S MEDICAL RELEASE FOR PARTICIPATION IN SILVERTON SCHOOL ACTIVITIES

Student Name	Date of Birth	Grade	
Address	City	State	Zip
Parent/Guardian's Name	Home #	Cell #	

The Silverton Public School Program PE and Outdoor Education Program is designed to expose students to a wide variety of recreational and physical activities. During the course of the school year, students generally participate in most, if not all, of the activities listed below.

I hereby certify that I have examined _____ and that the student was found physically fit to engage in the following activities for the _____ School Year. Activities in which the student should not participate are crossed out.

- | | | |
|-----------------------|-----------------|----------------------|
| Regular PE Class | Bike Riding | Mountain Bike Riding |
| Intermural Basketball | Rock Climbing | Ropes Courses |
| Intermural Volleyball | Ice Hockey | Sledding |
| Intermural Soccer | Downhill Skiing | Snowboarding |
| Intermural Softball | Snowshoeing | Cross Country Skiing |
| Intermural Tennis | Swimming | Hiking |
| Track & Field Events | | |

Conditions or Restrictions placed upon student participation in physical activities:

Additional Comments

Physician's Signature

Date

Clinic Contact Information

Parent/Guardian Signature

Date



Immunization

Certificate of Medical Exemption

Colorado law C.R.S. § 25-4-902 requires all students attending any school in the state of Colorado to be vaccinated against certain vaccine-preventable diseases, as established by Colorado Board of Health rule 6 CCR 1009-2, unless an exemption is filed. This law applies to students attending public, private and parochial kindergarten, elementary and secondary schools through 12th grade, colleges or universities, and child care facilities licensed by the Colorado Department of Human Services including child care centers, school-age child care centers, preschools, day camps, resident camps, day treatment centers, family child care homes, foster care homes, and Head Start programs. Students with a recorded immunization exemption may be kept out of a child care facility or school during a disease outbreak; the length of time will vary depending on the type of the disease and the circumstances of the outbreak. Medical exemptions need to be filed only once unless the student's information or school changes.

Please complete all required fields below and obtain all required signatures; incomplete forms will not be accepted.

Student Information:

Last Name:	First Name:	Middle Name:
Date of Birth:	Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> X	

Parent/Guardian Completing This Form: Check if an emancipated student or student over 18 years old

Last Name:	First Name:	Middle Name:
Relationship to student: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Legal Guardian		

School/Licensed Child Care Facility Information:

School Name/Licensed Child Care Facility:		
School District:	<input type="checkbox"/> Check if Not Applicable	
Address:		
City:	State:	Zip Code:

Required Vaccines for School Entry

Check each vaccine declined:	List medical contraindication(s) for each vaccine declined:
<input type="checkbox"/> Hepatitis B	
<input type="checkbox"/> Diphtheria, tetanus, pertussis (DTaP, Tdap)	
<input type="checkbox"/> Haemophilus influenzae type b (Hib)	
<input type="checkbox"/> Inactivated poliovirus (IPV)	
<input type="checkbox"/> Pneumococcal conjugate (PCV13)	
<input type="checkbox"/> Measles, mumps, rubella (MMR)	
<input type="checkbox"/> Varicella (chickenpox)	

Statement of Exemption

The physical condition of the above named student is such that vaccination would endanger their life or health or is medically contraindicated due to other medical conditions. The information I have provided on this form is complete and accurate.

REQUIRED Signature: _____ Date: _____
 Physician (MD, DO), Advanced Practice Nurse (APN), or Physician Assistant (authorized pursuant to section 12-240-107 (6), C.R.S.)

REQUIRED: _____ Professional License Number: _____
 (State/Territory)

Under Colorado law, you have the option to exclude your child's/your information from the Colorado Immunization Information System (CIIS). To opt out of CIIS, go to: www.colorado.gov/cdphe/ciis-opt-out-procedures. Please be advised that you will be responsible for maintaining your child's/your immunization records to ensure school compliance.



Immunization

Certificate of Nonmedical Exemption

Colorado law C.R.S. § 25-4-902 requires all students attending any school in the state of Colorado to be vaccinated against certain vaccine-preventable diseases, as established by Colorado Board of Health rule 6 CCR 1009-2, unless an exemption is filed. This law applies to students attending public, private and parochial kindergarten, elementary and secondary schools through 12th grade, colleges or universities, and child care facilities licensed by the Colorado Department of Human Services including child care centers, school-age child care centers, preschools, day camps, resident camps, day treatment centers, family child care homes, foster care homes, and Head Start programs. “Nonmedical exemption” means an immunization exemption based upon a religious belief whose teachings are opposed to immunizations or a personal belief that is opposed to immunizations. Prior to kindergarten, a nonmedical exemption must be filed each time a student is due for vaccines according to the schedule developed by the ACIP.^{1,2} From kindergarten through 12th grade, a nonmedical exemption must be filed every year during the student’s school enrollment/ registration process.¹ Students with a recorded immunization exemption may be kept out of a child care facility or school during a disease outbreak; the length of time will vary depending on the type of the disease and the circumstances of the outbreak.

Please complete all required fields below and obtain all required signatures; incomplete forms will not be accepted.

Student Information:

Last Name:	First Name:	Middle Name:
Date of Birth:	Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> X	

Parent/Guardian Completing This Form: Check if an emancipated student or student over 18 years old

Last Name:	First Name:	Middle Name:
Relationship to student: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Legal Guardian		

School/Licensed Child Care Facility Information:

School Name/Licensed Child Care Facility:		
School District:	<input type="checkbox"/> Check if Not Applicable	
Address:		
City:	State:	Zip Code:

Required Vaccines for School Entry - Place an “X” next to each vaccine for which you are claiming a nonmedical exemption.

<input type="checkbox"/>	Diphtheria, tetanus, pertussis (DTaP)	<input type="checkbox"/>	Inactivated poliovirus (IPV)
<input type="checkbox"/>	Tetanus, diphtheria, pertussis (Tdap)	<input type="checkbox"/>	Measles, mumps, rubella (MMR)
<input type="checkbox"/>	Haemophilus influenzae type b (Hib)	<input type="checkbox"/>	Pneumococcal conjugate (PCV13)
<input type="checkbox"/>	Hepatitis B	<input type="checkbox"/>	Varicella (chickenpox)

Statement of Exemption

I am the parent/guardian of the above-named student or am the student myself (emancipated or over 18 years of age) and am claiming a nonmedical exemption from the vaccine(s) indicated above. The information I have provided on this form is complete and accurate. I can review evidence-based vaccine information at www.colorado.gov/cdphe/immunization-education, www.spreadthevaxfacts.com/, www.ImmunizeForGood.com/ for additional information on the benefits and risks of vaccines and the diseases they prevent. I can contact the Colorado Immunization Information System (CIIS) at www.covaxrecords.org or my health care provider to locate my child’s/my immunization record.³

REQUIRED Signature: _____ Date: _____
Parent/Legal Guardian/Student (emancipated or over 18 years old)

REQUIRED Provider Signature Section:

REQUIRED Print Name, Title, and Signature: _____ Date: _____ <small>Physician (MD, DO), Advanced Practice Nurse (APN), Physician Assistant, Registered Nurse (RN) or Pharmacist (authorized pursuant to section 12-240-107 (6), C.R.S.)</small>
REQUIRED Colorado Professional License Number: _____

¹ Colorado Board of Health rule 6 CCR 1009-2: <https://www.sos.state.co.us/CCR/GenerateRulePdf.do?ruleVersionId=7698&fileName=6%20CCR%201009-2>

² 2021 Recommended Immunizations from Birth through 6 Years Old: www.cdc.gov/vaccines/parents/downloads/parent-ver-sch-0-6yrs.pdf. Based on this schedule, a nonmedical exemption would be submitted at 2 months, 4 months, 6 months, 12 months and 18 months of age.

³ Under Colorado law, you have the option to exclude your child’s/your information from CIIS at any time. To opt out of CIIS, go to www.colorado.gov/cdphe/ciis-opt-out-procedures. Please be advised you will be responsible for maintaining your child’s/your immunization records to ensure school compliance.