



GRIC SCHOOLS

School Yr. 2024-2025

School Health Services

3042 W. Queen Creek Rd, Chandler, AZ 85286

Parents/Guardians,

In order to provide the best care for your child during the 2024-25 school year, you need to complete the enclosed forms in the enrollment packet. Forms to be completed include the following:

SCHOOL HEALTH SERVICES ENROLLMENT PACKET

1. School Health Services-Health Information and Consent to Treat Form. This form is required annually for students attending GRIC schools, in order for your child to receive health services from the school nurse. It also serves as your child's health information and contact information in case of an emergency.
2. Over The Counter Medication Form-required if you would like your student to receive over the counter medication from the school nurse.
3. School Lice Information Sheet: Please contact your nurse for more information.

OPTIONAL COORDINATING WITH GILA RIVER HEALTH CARE DEPARTMENTS CONSENTS FOR THEIR SERVICES

1. Vision Program (Optional) - Your signature is required for Eye Clinic Services during schools hours.
2. Dental Program On-Site Dental Clinic (Optional) - Your signature is required for dental services during school hours.
3. Community Outreach Mobile Unit (Optional) - Your signature is required for community outreach services during school hours. If you have questions related to the services provided on the community outreach mobile unit please contact Robin Henry Family Nurse Practitioner at 520-517-0693.
4. Behavioral Health Services-School Counseling Program (Optional) - Your signature is required for BHS Counseling Program Services during schools hours.
5. Primary Care Audiology Program (Optional) Your signature is required for audiology services during school hours.

Gila River Health Care Contact Information:

Pediatric Department's Ext. 7337

Hu Hu Kam Memorial Hospital (520-562-3321)

Komatke Health Center (520-550-6000)

Hau'pal (Red Tail Hawk) (520-796-2600)

Medical Transportation Department: HHK Ext.1384, KHC Ext.6328 & RTH Ext.1565

If your student will need medical treatments during the school year (inhalers, nebulizer treatments, daily prescribed medication while at school, blood glucose testing), you will need to visit with the School Health nurse. Special arrangements and proper forms must be completed and signed by parent/guardian before treatments/prescribed medication can be given at school.

IMMUNIZATION RECORDS

*Please include a current copy of your student's immunization record. It will be required to enroll your student. If your child is missing the required immunizations, they **WILL BE EXCLUDED FROM SCHOOL** until the needed immunizations are received and documented proof is presented to the school health nurse.*

"Healthy children make better students, and better students make healthy communities"



School Health Services

School Year 2024-2025 Lice Information for Parents/Guardian Gila River Indian Schools

- I understand it is my responsibility to keep my child's hair free of head lice. I understand I need to have my child's hair cleaned in a timely manner to reduce school absence.
- I will review and follow the schools lice guidelines in my student's school handbook for nits, lice, or head sores related to lice infestation.
- The school nurse or school staff will contact me either by phone or letter if my child is found to have nits, lice, or head sores related to lice infestation. If I treat and comb out my child's hair, I may send my student back to school the next day. A pharmacy referral for lice shampoo, lice treatment options and a 14 day Lice educational flyer will be sent home with my child found to have head lice.
- Any GRHC Pharmacy (HHK, RTH or KHC) will provide a lice shampoo kit at your request, for your child/children who have lice. (You do not need to be seen by a doctor or have a referral).
- In addition, the school nurse office has a lice shampoo kit for a child who has lice. The parent/legal guardian MUST arrive to the nurse office at your child's school and sign a form, then the nurse will provide a lice shampoo kit for your child. Contact the school nurse for more information.
- The Gila River Health Care Public Health Nursing (PHN) Department may assist the family with managing head lice at home at the request of the family and the school nurse can send home a PHN referral as well.

WHAT WE DO:



Encourage positive social support with peers



Support and counsel students during tough times



Help students cope with and overcome challenges



Assist students with positive behavior changes and improved decision making



Social/Emotional Learning



Coordinate with families and Community Schools to meet students' mental health needs



Provide Behavioral Health counseling during the school day

WHAT WE DON'T DO:

- Give students quick answers to complex concerns
- Tell students what to do
- Judge a student's behavior

Behavioral Health Services

GILA RIVER HEALTH CARE

WHO WE ARE:

- We have experience working with children and families
- We connect students and their families to additional Behavioral Health Services as needed through GRHC
- Behavioral Health School Counselors are licensed by the Arizona Board of Behavioral Health Examiners

Contact us:

520-796-2631

grhcschoolcounseling@grhc.org

"WE'RE HERE TO HELP!"

The Behavioral Health School Counseling Program (BHSC) is provided through Tobacco Tax funding from the Gila River Indian Community.

In the event of a
mental health crisis call:

National Suicide Prevention Lifeline: 988

GRIC CRISIS HOTLINE: 1-800-259-3449



Gila River
HEALTH CARE



Behavioral Health School Counseling Services

grhcschoolcounseling@grhc.org
520-796-2631

IS YOUR CHILD STRUGGLING?

BEHAVIOR PROBLEMS CAN BE SIGNS OF...



Anxiety or excessive worry



Depression



Interpersonal problems (issues with family, friends, and/or teachers)



Self Esteem Issues



Attention Issues

WHERE WE ARE LOCATED:

- Blackwater Community School
- Casa Blanca Community School
- Gila Crossing Community School
- Maricopa Village Christian School
- Sacaton Elementary and Middle Schools
- Saint Peter's Indian Mission School



HOW DOES COUNSELING HELP?

Counseling has been shown to help students...

- Increase self confidence
- Problem Solving
- Cope with depression
- Develop healthy coping skills
- Improve interpersonal skills
- Learn to make better decisions
- Manage anxiety
- Decrease behavior issues
- Increase anger management skills
- Increase academic success

MENTAL HEALTH AFFECTS US ALL

We all face life challenges that can be stressful, overwhelming, and cause strong emotions in both adults and children. School, learning challenges, peer and family relationships, depression, isolation, and anxiety affect both students and their families. A mental health crisis is emerging among our youth. Behavioral Health School Counselors are here to provide help and support through these challenges.

STUDENT HEALTH INFORMATION SHEET

Gila River Indian Community Schools

Child's Name: _____ Date of Birth: _____ Person ID #: _____ M / F
 Parent/Guardian Name: _____ Lives with: Father / Mother / Guardian Other: _____ Grade: _____
 Physical Address: _____ Home Phone: _____ Cell: _____ Work: _____

CHILD'S HEALTH HISTORY: Please circle all health conditions that apply to the child:

ADHD	Bleeding Problems	Ear Infections	Heart Surgery date: _____	Seizures
Anemia	Blood Transfusion	Hearing Loss Date: _____	History of Anxiety	Sinus Problems
Asthma	Cold Sores	Heart Murmur	HIV/AIDS	Thyroid Problems
Behavioral Issues	Depression	Hepatitis Type: _____	Lung Problems	TB (Tuberculosis)
Bladder/Toileting Problems	Diabetes /Prediabetes	High Blood Pressure	Rheumatic Fever	Other: _____

History of COVID-19 (circle): Yes or No

☐ No Known Allergy

<input type="checkbox"/> Yes <input type="checkbox"/> No Food Allergy _____	(Circle Reaction)	(Epi-Pen Needed)
<input type="checkbox"/> Yes <input type="checkbox"/> No Latex Allergy _____	Rash/Hives or Trouble Breathing	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No Medication Allergy: _____	Rash/Hives or Trouble Breathing	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No Other Allergy: _____	Rash/Hives or Trouble Breathing	<input type="checkbox"/> Yes <input type="checkbox"/> No

ANSWER ALL QUESTIONS ABOUT YOUR CHILD'S CURRENT HEALTH-If Yes, please list Reason

☐ Yes ☐ No My child has a **Counselor** or **Case Manager** with GRHC-BHS: Name: _____
 My child receives behavioral health services from another organization: _____

☐ Yes ☐ No - Is your child currently under medical care? _____

☐ Yes ☐ No - Has your child ever been hospitalized? _____

☐ Yes ☐ No - Past Surgery, please list and date? _____

☐ Yes ☐ No - Activity Restrictions? Please describe: _____

☐ Yes ☐ No - Special Accommodations Needed: _____

☐ Yes ☐ No - Is your child taking any medications at **HOME**?(List) _____

☐ Yes ☐ No - Will your child take **ANY** doctor-prescribed **MEDICATION AT SCHOOL**? _____

If Yes, see your school nurse, you must fill out **MEDICATION CONSENT FORMS**.

All medication(s) must be in the original container with a valid (non-expired) pharmacy prescription label.

All medication(s) MUST be brought to the school nurse by an ADULT.

☐ Yes ☐ No My child is supposed to wear glasses? (circle) Full-Time Use / Part Time Use / Reading only

☐ Yes ☐ No My child has seen an eye doctor: **Last Eye Exam Date:** _____ (Glasses Broken/Lost) circle

I understand and agree that it is my responsibility to notify the school nurse and health providers at GRHC of any changes in the information recorded on this form. I certify that the information I have provided on this School Health Information form is accurate, true, and correct.

X _____
 Print Name of Parent/ Legal Guardian

X _____
 Signature

X _____
 Date

All records will be maintained in accordance with the Health Insurance Portability and Accountability Act (HIPAA) and Family Educational Rights and Privacy Act (FERPA), as applicable. By signing this release, you authorize and consent to disclosure of health information on a need-to-know basis for the provision of health care services in accordance with HIPAA and FERPA.

SHS Office Use Only RN Initials: IZ: _____ ASIIS: _____ MIDAS: _____ NextGEN: _____ HIMs: _____ Teacher: _____

☐ Blackwater Community School ☐ Casa Blanca Community School ☐ St. Peter Indian Catholic Mission
☐ Sacaton Elementary or ☐ Middle School ☐ MVC School ☐ Gila Crossing Elementary or ☐ Middle School

Teacher: _____

Grade: _____

School: _____



School Health Services School Year 2024-2025

SCHOOL HEALTH SERVICES CONSENT TO TREAT Gila River Indian Community Schools

Child's Name: _____ Date of Birth: _____ Person ID #: _____ M / F

EMERGENCY CONTACTS FOR THE SCHOOL HEALTH NURSE OFFICE: If I am unable to be reached, school authorities have my permission to contact and release my child to the following three individuals if my child becomes ill or is injured:

<u>NAME</u>	<u>Relationship</u>	<u>Phone: Home and Cell</u>
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1. _____	_____	_____
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2. _____	_____	_____
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3. _____	_____	_____
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The SHS Program includes but is not limited to, providing Registered Nursing services for your child while attending school within the Gila River Indian Community. Services include health education, annual health screenings, nursing assessments, nursing care and treatment of injury/illness, emergency care, immunization administration and immunization surveillance, infection prevention measures, case management/care coordination, monitoring acute and chronic health conditions.

If Prescription Medication is needed while at School:

- A School RN will assist the student with prescription medication while at school.
- A parent/guardian must sign a SHS Medication Administration Record Consent form for each medication needed.
- An adult **MUST** bring the medication to the school nurse's office.
- Medication must be in the original container with the child's valid (non-expired) prescription label.
- Trained staff may assist the student with their prescription medication while at school.
- The inhaler and epi-pen must have a valid (non-expired) prescription label with the student's name.
- Students may self-carry an inhaler or epi-pen with a parent/legal guardian signed SHS self-carry consent form.

If my child experiences a life-threatening emergency while at School:

- The School RN/trained School personnel will administer epinephrine when indicated for a severe anaphylactic allergic reaction. (911 will be called immediately following administration).
- The School RN/trained school personnel will administer Naloxone HCL (Narcan) for life-threatening overdose when indicated. (911 will be called immediately following administration).

Emergency Contact List:

I request the school to contact me in case of an accident or injury/illness. If the school is unable to reach me, I hereby authorize the school to contact one of the adults listed above. If the school cannot reach the adults listed above, the school may make whatever arrangements necessary to provide care and treatment for my child, including call 911. School personnel have my permission to request transport of my child to the nearest emergency room. I understand and agree that I will be responsible for emergency medical services fees.

SHS Health Education Classes: Include, but not limited to, the human body, hygiene, emotional and personal health, health promotion, nutrition, wellness, lice prevention, anti-bullying, infection prevention measures, safety, puberty and medical health careers.

I am the parent/legal guardian of the student listed above, and I give consent for my child to receive the SHS program services for the academic school year 2024-25. I understand that if guardianship changes, the legal guardian must sign a new consent. The school nurse may share my child's medical condition with the alternative contact listed above, if I cannot be reached.

X

Print Name of Parent/Legal Guardian

X

Signature

X

Date



School Health Services School Year 2024-2025

SCHOOL HEALTH SERVICES HEALTH INFORMATION RELEASE

Teacher: _____ Grade: _____ School: _____

Child's Name: _____ Date of Birth: _____ Person ID #: _____ M / F

- All healthcare information is confidential. By signing this consent form, you are giving the GRHC school nurse permission to communicate and share your child's health information with school personnel. The school nurse will only share certain health information with school personnel who need to know for your child's safety while at school. The school nurse will treat health information with confidentiality.
- By signing this consent form, you permit the school nurse to obtain your child's immunization record, which may include their COVID-19 vaccination record, and share it with school administration on a need-to-know basis.
- By signing this consent form, you permit the school nurse to obtain your child's COVID-19 test results from their GRHC medical record and share them with school administration on a need-to-know basis.
- By signing this consent form, you are giving permission for your child's healthcare information to be shared with other GRHC healthcare providers to coordinate healthcare services and continuity of care. The information may include, but is not limited to, COVID-19 test results, eyeglass wear/vision/ hearing screening results, and other chronic health conditions such as asthma, diabetes, seizures, heart condition(s), or severe allergies.

I am the parent/legal guardian of the child named above. My signature below indicates that I have read and understand the information above. The SHS Health Information Release is for the academic year (SY 24-25). I understand that if guardianship changes, the legal guardian must sign a new consent.

X

X

X

Print Name of Parent/Legal Guardian

Signature

Date

Teacher: _____ Grade: _____ School: _____



School Health Services School Year 2024-2025

Parent/Guardian Consent for Over-The-Counter and Non-Prescription Medication Administration During School Hours

There are specific procedures when your child is to be given over-the-counter medications during school hours.

Child's Name: _____ Date of Birth: _____ Person ID #: _____ M / F

Homeopathic and naturopathic remedies are not FDA-approved; therefore, the nurse will not administer them at school. I understand my child will

NOT be permitted to carry prescribed, herbal medicinal substances or over-the-counter medication(s) on campus. Student violation of this policy may result in disciplinary action by the school administration

OPT-OUT ☐ **NO, I do not want my child to receive Over The Counter Medication at School**

If your doctor has prescribed over-the-counter medication for your child, the parent/guardian must follow guidelines:

- All medication(s) must be in the original container with a valid (non-expired) pharmacy prescription label.
- An ADULT must bring all medication(s) to the school nurse office.
- Check with your pharmacy if you need assistance obtaining medication labels.

OVER-THE-COUNTER MEDICATIONS:

The school nurse's office has the following over-the-counter medications. The GRHC Pharmacy provides them with the following:

Acetaminophen (also known as Tylenol) Tablets and or Chewable Tablets, Bacitracin (also known as Neosporin) Ointment, Diphenhydramine (also known as Benadryl) Capsule and Suspension, Hydrocortisone Cream 1%, Refresh Plus-Eye Lubricant (Carboxymethylcellulose sodium 0.5%), Sterile Isotonic Buffered Solution also known as eye wash.

The school nurse will administer over-the-counter medication in a dosage consistent with the child's weight and age.

OVER-THE-COUNTER LICE SHAMPOO:

Rid Lice Shampoo Kit (Piperonyl Butoxide 4% Pyrethrum extract) or GRHC Pharmacy has in stock for lice shampoo.

OPT-OUT ☐ **NO, I do not want a lice shampoo kit for my child.**

Should my child be identified as having head lice while at school, the parent/legal guardian may request a lice shampoo kit. The parent or legal guardian **MUST** pick up the lice shampoo kit from the nurse's office **IN PERSON** and sign a form verifying receipt.

I have read and understand the above and permit the GRHC School RN to assist my child with administering over-the-counter medication (listed above).

X

Print Name of Parent/Legal Guardian

X

Signature

X

Date



School Health Services School Year 2024-2025

Parent/Guardian CONSENT to TREAT for Additional Health Services (Optional)

Gila River Health Care (GRHC) Departments (page 1 of 3)

Child's Name: _____ Date of Birth: _____ Person ID#: _____ M / F

Home Phone: _____ Cell phone : _____ Work phone: _____

GRHC- OPTOMETRY:

OPT-OUT ☐ NO, I do not want Optometry Services

I GIVE MY CONSENT FOR MY CHILD TO RECEIVE THE FOLLOWING OPTOMETRY SERVICES:

Treatment/Procedure: Complete Eye Exam with possibility of dilation drops to both eyes, 1 hour duration, with the effect of the drops (mild blur and dilated pupils) lasting several hours (which is normal). Not all children will be dilated each year. I authorize school personnel to provide transportation to the Gila River Health Care Optometry Clinic for an eye examination appointment for my child. I understand that my child may have his/her eyes dilated at this appointment. I also give permission for GRHC Optical staff, school or school health staff to assist with the selection of frames.

I understand that at the time of my child's eye exam, emotional wellness screening questions may be asked as required by the provider.

GRHC- Primary Care Department (PCD)-Clinical AUDIOLOGIST:

OPT-OUT ☐ NO, I do not want Audiology Services

I GIVE MY CONSENT FOR MY CHILD TO RECEIVE THE FOLLOWING AUDIOLOGY SERVICES:

Treatment/Procedure: Complete hearing test, 30 minutes to 1 hour. I authorize school personnel to provide transportation to the Gila River Health Care Audiology Clinic for a hearing examination appointment for my child. If you have any questions, please direct them to the Audiology Department at GRHC (520)796-2965.

My signature indicates I hereby give consent for my child to receive services from GRHC Optometry and Audiology. I understand if I select OPT-OUT my child will not be seen for services. I understand this consent is in effect for the following GRHC Departments: Optometry, PCD-Audiology for the academic school year 2024-2025. I understand and agree that my child's information may be shared with GRHC health care staff and school personnel as needed.

X _____
Print Name of Parent/Legal Guardian

X _____
Signature

X _____
Date



School Health Services School Year 2024-2025

Parent/Guardian CONSENT to TREAT for Additional Health Services (Optional)

Gila River Health Care (GRHC) Departments (page 2 of 2)

Child's Name: _____ Date of Birth: _____ Person ID #: _____ M / F

Home Phone: _____ Cell Phone: _____ Work phone: _____

GRHC-Dental Services-On Site at Schools:

OPT-OUT ☐ NO, I do not want Dental Services

I GIVE MY CONSENT TO THE FOLLOWING DENTAL SERVICES:

- ☐ Yes ☐ No- Education Program- Education about tooth decay (cavities), gum disease and prevention.
☐ Yes ☐ No- Dental Exam- X-Rays and examination to identify dental problems requiring treatment.
☐ Yes ☐ No- **Dental Screening** and Topical Fluoride application to teeth. (A visual inspection of the child's mouth and teeth).

Please note: A Dental Screening is NOT the same as a Dental Exam. Patients will be referred to the Dental Clinic for a comprehensive Dental Examination with x-rays.

- ☐ Yes ☐ No- Dental Cleaning & Sealants- plastic coatings to seal teeth & keep bacteria out to prevent cavities.
☐ Yes ☐ No- Root canals, fillings, crowns, removal of baby teeth, use of local anesthesia (numbing)

All dental services are being provided by GRHC. All treatment supervised by licensed/credentialed Dentist/Dentist specialist. The school is not responsible or liable for any care rendered on site. All services are optional and require written consent as outlined above. A new consent may be submitted at any time if you change your mind regarding level of services to be rendered. If you have any questions, please direct them to Director of Dental Services GRHC (602)528-1209.

- ☐ Yes ☐ No- Does your child have any **MEDICAL or HEART CONDITION** that **may require medication before dental treatment?** If so, list the medical reasons _____

GRHC-Community Outreach Mobile Unit (COMU) On Site at Schools:

OPT-OUT ☐ NO, I do not want COMU Services

I GIVE MY CONSENT TO THE FOLLOWING COMU SERVICES:

Immunizations, Acute and Chronic Care visits, Well Child Checks, Sports Physicals, Labs, Diabetes screening and/or follow up. I hereby give consent for my child to receive medical care by the Gila River Health Care Community Outreach Mobile Unit Family Nurse Practitioner. I understand that all medical treatment plans will be discussed with me and sent home with the patient. I also understand that I may be able to reach the Family Nurse Practitioner through her work cell phone at **(520) 517-0693** with any questions or concerns.

My signature indicates I hereby give consent for my child to receive services from **GRHC Dental and COMU**. **I understand if I select OPT OUT my child will not be seen for services.** I understand this consent is in effect for the following GRHC Departments: Dental Mobile Unit and COMU for the academic school year **2024-2025**. I understand and agree that my child's information may be shared with GRHC health care staff and school personnel as needed.

X _____
Print Name of Parent/Legal Guardian

X _____
Signature

X _____
Date



School Health Services School Year 2024-2025

Parent/Guardian CONSENT to TREAT for Additional Health Services (Optional)

Gila River Health Care (GRHC) Departments (page 3 of 3)

Child's Name: _____ Date of Birth: _____ Person ID#: _____ M / F

Parent/Guardian: _____

Home Phone: _____ Cell Phone: _____ Work phone: _____

BEHAVIORAL HEALTH SCHOOL COUNSELING PROGRAM (Optional)

Gila River Health Care (GRHC) has established a Behavioral Health School Counseling (BHSC) Program with your child's school to provide support/counseling services during school hours intended to promote social emotional wellness, educational progress and success. If you would like your child to be eligible to receive these services, you will need to complete the "opt in" section below. If you do not want your child to receive these services, you may opt out of the program by completing the "opt out" section below. Your decision to opt in or out of the program will not prevent your child from receiving services in crisis situations.

Please check ONLY ONE BOX below

OPT-IN TO THE BHSC PROGRAM: (Check only 1 of the 2 boxes)

☐ I want my child to be eligible receive support/counseling services as needed through the BHSC Program.

I authorize the GRHC BHSC Program to provide support/counseling services (in person or through virtual means), to the extent consistent with Program requirements and in coordination with my child's school, when determined appropriate to support my child's social-emotional wellness, educational progress and success.

I understand that if it is determined that my child would benefit from ongoing behavioral health services such as ongoing groups, one-on-one therapy or referrals to other behavioral health services outside the BHSC Program, such services will be discussed with me and a separate consent form will be sent home with my child before any of these services are provided. I authorize the BHSC Program to share my child's information with school personnel only as necessary to facilitate the services hereunder (including providing a copy of this form to the school) and to protect the health and safety of my child and others.

OPT-OUT OF THE BHSC PROGRAM: (Check only 1 of the 2 boxes)

☐ I do not want my child to be eligible to receive support/counseling services through the BHSC Program. I understand that this means that my child will not receive behavioral health services (except in crisis situations) during school hours for the 2024-2025 school year unless consent is provided at a later time. I authorize the BHSC Program to provide a copy of this form to my child's school.

For questions contact: 520-796-2631 grhcschoolcounseling@grhc.org

X

Print Name of Parent/Legal Guardian

X

Signature

X

Date

Gila River Health Care Contact Information:

Hu Hu Kam Memorial Hospital: 602-528-1200 / 520-562-3321

Komatke Health Center: 520-550-6000

Hau'pal (Red Tail Hawk) Health Center: 520-796-2600