WESTERN HILLS ACADEMY

524 Thunderbird El Paso, TX 79912 / 915-584-6642

ENROLLMENT INFORMATION

Please Print

Facility Name: **Western Hills Academy**	Director's Name: ***Patricia Aguirre*** Rev June 2015	
Child's Name:	Date of Birth:	
Child's Address:	Child's Home Phone:	
Date of Admission:	Days Enrolled- (circle) M T W TH F - Grade level ELC, Pre-k, Kinder, 1, 2, 3, 4, 5	
Persons legally responsible: TX DL # SS #	Address **(if different from child's)** E-mail Address	

	Mother's Phone #	Father's Phone #	Guardian's Phone #
List telephone numbers where parents/guardian may be reached while child is in care: Permission to Text: (Y) (N) Mobile Carrier:	Home: Work: Cell:	Home: Work: Cell:	Home: Work: Cell:
List a person to call in case of an emergency if parent or guardian cannot be reached: *(This person may have access to my child's health information.)*	**1** Name: *Phone:* *Address:* *Relationship*	**2** Name: *Phone:* *Address:* *Relationship*	**3** Name: *Phone:* *Address:* *Relationship*
In addition to the above; I hereby authorize the day care facility to allow my child to leave the facility with the following persons:	Name: Phone:	Name: Phone:	Name: Phone:

I hereby ____ GIVE ____ do not give - my consent for my child to participate in field trips with advance notice. (N/A for Toddlers or Twos)

I hereby ____ GIVE ____ do not give - my consent for my child to be photographed for T.V., newspapers, Facebook, and school website

Photos for Assessment Circle (Y) (N) Photo Yearbooks Circle (Y) (N)

Allowed to apply if needed: Neosporin? (Y) (N) Hand Sanitizer? (Y) (N) Sun Screen? (Y) (N)

Insect Repellant containing DEET? (Y) (N)

List any special needs or problems your child may have, including known allergies, existing illnesses, previous serious illness and injuries, any disabilities, any hospitalizations during the past 12 months, and any medication prescribed for long-term use and any other information which staff should be aware of:

<u>AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION:</u> In the event that I cannot be reached to make arrangements for emergency medical attention, I authorize the facility director or person in charge to take my child to:

Physician	Address	Phone
Dental Emergency	Address	Phone
Hospital	Address	Phone

I give my consent for this facility to secure any and all necessary emergency medical care for my child. It is understood that the school or its representatives do not assume any financial responsibility for any expenses that might be incurred for said emergency treatment. It is further understood that school authorities will notify us as soon as possible following the emergency, but in no way is treatment to be delayed until we have been notified. ***<u>My health insurance information copied on the back of this form.</u>***

I have received a copy of the Family Handbook. I agree to abide by all such policies and procedures as defined within.

All above is accurate and agreed upon.

Signature - Parent or Legal Guardian ______________________ Director ______________________

TB Questionnaire

Name of Child____Date of Birth ______________

Child Care Home/Center______________________ Date____________________

Tuberculosis (TB) is a disease caused by TB germs and is usually transmitted by an adult person with active TB lung disease. It is spread to another person by coughing or sneezing TB germs into the air. These germs may be breathed in by the child.

Adults who have active TB disease usually have many of the following symptoms: cough for more that two weeks duration, loss of appetite, weight loss of ten or more pounds over a short period of time, fever, chills and night sweats.

A person can have TB germs in his or her body but not have active TB disease (this is called latent TB infection or LTBI).

Tuberculosis is preventable and treatable. TB skin testing (often called the PPD or Mantoux test) is used to see if your child has been infected with TB germs. No vaccine is recommended for use in the United States to prevent tuberculosis. The skin test is not a vaccination against TB.

We need your help to find out if your child has been exposed to tuberculosis.

Place a mark in the appropriate box:	Yes	No	Don't Know
TB can cause fever of long duration, unexplained weight loss, a bad cough (lasting over two weeks), or coughing up blood. As far as you know: has your child been around anyone with any of these symptoms or problems? or has your child had any of these symptoms or problems? or has your child been around anyone sick with TB?			
Was your child born in Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe or Asia?			
Has your child traveled in the past year to Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe or Asia for longer than 3 weeks? If so, specify which country/countries?____________________			
To your knowledge, has your child spent time (longer than 3 weeks) with anyone who is/has been an intravenous (IV) drug user, HIV-infected, in jail or prison or recently came to the United States from another country?			

Has your child been tested for TB? Yes___ (if yes, specify date ____/____) No___
Has your child ever had a positive TB skin test? Yes___ (if yes, specify date ____/____) No___

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Parent __________________________________
Signature/date

If positive, referral to healthcare provider Yes___ No___

If yes, name of provider ____

Adapted for El Paso CCL

TEXAS Department of State Health Services

FARE Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

PLACE PICTURE HERE

Name: ______________________ D.O.B.: ____________

Allergy to: ______________________

Weight: __________ lbs. Asthma: ☐ **Yes (higher risk for a severe reaction)** ☐ **No**

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following allergens: ______________________

THEREFORE:

☐ If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.

☐ If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.

FOR **ANY** OF THE FOLLOWING:

SEVERE SYMPTOMS

LUNG
Short of breath, wheezing, repetitive cough

HEART
Pale, blue, faint, weak pulse, dizzy

THROAT
Tight, hoarse, trouble breathing/swallowing

MOUTH
Significant swelling of the tongue and/or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting, severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.

- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE
Itchy/runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea/discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM **A SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: ______________

Epinephrine Dose: ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: ______________

Antihistamine Dose: ______________

Other (e.g., inhaler-bronchodilator if wheezing): ______________

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PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

Western Hills Academy

524 Thunderbird Dr.
El Paso, TX. 79912
Tel: (915) 584-6642

(Form to be completed by child's physician and returned to school with enrollment packet)

Physician's Statement

I have examined ______________________________ and see no physical or emotional reason to restrict participation in activities at school.

I have noted the following, if applicable:

Restrictions of activity:

Special attention or care needed:

Date____________________ Signed ______________________________________
(Physician)

***Please attach a copy of the child's immunization record to this form**

Revised June 2015