ATTACHMENT A

BUREAU OF INDIAN EDUCATION

AUTHORIZATION TO ADMINISTER PRESCRIBED/OVER-THE-COUNTER MEDICATION

PART I—TO BE COMPLETED BY THE PARENT/GUARDIAN

I hereby request and authorize designated and properly instructed school personnel to administer prescribed medication as directed by the prescribing physician or other duly licensed provider (PART II below). I certify that I have legal authority to consent to the administration of prescribed medication following the provider's order. I understand additional prescriber/parent authorizations will be necessary for each medication to be administered, and if the dosage of the medication is changed. If necessary, I authorize **the designated school health care official to communicate with the prescriber or the student's health care provider as allowed by HIPAA.**

STUDENT INFORMATION

Student Name _____ **Date of Birth** _____ **Gender M** ___ **F** ___
Last First MI

School _____ **Grade**_____ **School Year**_____ **Height (inches)** _____ **Weight (lbs)** _____

List all medication(s) student is taking, including over-the-counter medication(s):

_____

_____

List any known drug allergies/reactions: _____

Parent/Guardian Signature _____ **Date** _____

Contact Number(s): _____ **(Day)** _____ **(Evening)**

PART II—TO BE COMPLETED BY THE PRESCRIBER

PLEASE USE A SEPARATE FORM FOR EACH MEDICATION

Name of Medication: _____ **Diagnosis:** _____

Dosage: _____ **Time(s)/Frequency to be given:** _____

Route of Administration: _____ **PRN (as needed)** ___**Yes** ___**No** **If PRN, (signs/symptoms):** _____

_____

Side Effects: _____

Begin Medication: _____ **Stop Medication:** _____
Date Date

Special Instructions:

Refrigeration required? ____Yes ___No
Is medicine a controlled substance? ____Yes ___No
Is this an emergency self carry/self administration medication? ___Yes ___No
Has student been instructed in the proper self administration of medicine? ___Yes ___No

Prescriber's authorization for self carry/self-administration of emergency medication: _____
Signature Date

Prescriber's Name/Title: _____ **Phone**_____
(Type or Print)

Address:_____ **Fax**_____

Prescriber's signature: _____ **Date**_____

PART III—TO BE COMPLETED BY School Nurse/Other Duly Licensed Health Care Provider

- ☐ Parts I and II above are completed, including signatures.
- ☐ Prescription medication is properly labeled by a pharmacist and within the expiration date.
- ☐ Medication label and prescriber order are consistent.
- ☐ Over-the-counter medication is in an original container with manufacturer's dosage label intact.

Principal/Authorized School Personnel Signature _____ **Date**_____

ATTACHMENT B

BUREAU OF INDIAN EDUCATION

AUTHORIZATION TO ADMINISTER PRESCRIBED/OVER-THE-COUNTER MEDICATION

INFORMATION AND PROCEDURES

1. No medication will be administered in school or during school-sponsored activities without the parent's/guardian's written authorization and a written physician or other licensed health care provider order. This includes both prescription and over-the-counter (OTC) medications. An exception will be made for students living at a boarding school or a dormitory and whose parent/guardian has granted permission for emergency care for the student.
2. The parent/guardian is responsible for completing Part I and obtaining the physician's statement on Part II. This is required every school year for each new or continuing order or if there is a change in dosage or time of administration during the school year. Information necessary includes: child's name, diagnosis, medication name, dosage, time of administration, duration of medication, side effects, physician signature, and date.
3. The medication must be delivered to the school by the parent/guardian or through acceptable mailing services and under special circumstances by an adult designated by the parent/guardian.
4. All prescription medication must be provided in an original container with the pharmacist's label attached. If applicable, a duplicate bottle may be requested so some of the medicine can be kept at home. Non-prescription OTC medication must be in the container with the manufacturer's original label so dosage information and expiration date are viewable.
5. The parent/guardian is responsible for collecting any unused portion of a medication within one week after expiration of the physician's order or at the end of the school year. Medication not claimed within that time period will be destroyed using approved disposal methods by the FDA or EPA (see BIE Medication Administration policy).
6. A physician's or other duly licensed provider's order and parental permission are necessary for self-carry/self-administered emergency medications such as inhalers for asthma and EpiPens or Auvi-Q for anaphylaxis, Insulin for diabetes, and Sumatriptan for migraines. It is imperative the student understands the necessity for reporting to the health staff or teacher that they have self-administered their inhaler or have self-administered an EpiPen, so emergency services can be sought. Students that self-carry/self-administer emergency medications will have an Individualized Health Plan so school nurse/school health assistant can communicate with school staff.
7. When applicable, pursuant to specifications on the medication authorization form, the school nurse or other licensed health care professional will assess the student to determine if it is appropriate to administer a particular OTC medication to a student, and to determine if the student's symptoms could be alleviated first without a medicine. A non-licensed provider will observe the student and report their observations to a nurse or other licensed health care provider.

WYOMING HIGH SCHOOL ACTIVITIES ASSOCIATION

SCHOOL PHYSICAL EXAMINATION

MEDICAL RECORD

PHYSICIANS STATEMENT MUST BE DATED AFTER MAY 1 TO BE VALID FOR THE UPCOMING SCHOOL YEAR

Name _____ Sex _____ Age _____ Date of Birth _____

Grade _____ School _____ Sport(s) _____

Address _____ Phone _____

Personal Physician _____

In case of emergency, contact

Name _____ Relationship _____ Phone (H) _____ (W) _____

Explain "Yes" answers below. Circle questions you don't know the answers to.

	Yes	No
1. Have you had a medical illness or injury since your last check up or sports physical?	[ ]	[ ]
2. Have you ever been hospitalized overnight?	[ ]	[ ]
3. Are you currently taking any prescription of nonprescription (over-the-counter) medications or pills or using an inhaler?	[ ]	[ ]
4. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	[ ]	[ ]
5. Have you ever passed out during or after exercise?	[ ]	[ ]
Have you ever been dizzy during or after exercise?	[ ]	[ ]
Have you ever had chest pain during or after exercise?	[ ]	[ ]
Do you get tired more quickly than your friends do during exercise?	[ ]	[ ]
Have you ever had racing of your heart or skipped heartbeats?	[ ]	[ ]
Have you had high blood pressure or high cholesterol?	[ ]	[ ]
Have you ever been told you have a heart murmur?	[ ]	[ ]
Has any family member or relative died of heart problems or of sudden death before age 50?	[ ]	[ ]
Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	[ ]	[ ]
Has a physician ever denied or restricted your participation in sports for any heart problems?	[ ]	[ ]
6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	[ ]	[ ]
7. Have you ever had a head injury or concussion?	[ ]	[ ]
Have you ever been knocked out, become unconscious, or lost your memory?	[ ]	[ ]
Have you ever had a seizure?	[ ]	[ ]
Do you have frequent or severe headaches?	[ ]	[ ]
Have you ever had numbness or tingling in your arms, hands, legs, or feet?	[ ]	[ ]
Have you ever had a stinger, burner, or pinched nerve?	[ ]	[ ]
8. Have you ever become ill from exercising in the heat?	[ ]	[ ]
9. Do you cough, wheeze, or have trouble breathing during or after activity?	[ ]	[ ]
Do you have asthma?	[ ]	[ ]
Do you have seasonal allergies that require medical treatment?	[ ]	[ ]

	Yes	No
10. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	[ ]	[ ]
11. Have you had any problems with your eyes or vision?	[ ]	[ ]
Do you wear glasses, contacts, or protective eyewear?	[ ]	[ ]
12. Have you ever had a sprain, strain, or swelling after injury?	[ ]	[ ]
Have you broken or fractured any bones or dislocated any joints?	[ ]	[ ]
Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	[ ]	[ ]

If yes, check appropriate box and explain below

[ ] Head	[ ] Elbow	[ ] Hip
[ ] Neck	[ ] Forearm	[ ] Thigh
[ ] Back	[ ] Wrist	[ ] Knee
[ ] Chest	[ ] Hand	[ ] Shin/calf
[ ] Shoulder	[ ] Finger	[ ] Ankle
[ ] Upper Arm		[ ] Foot

	Yes	No
13. Do you want to weigh more or less than you do now?	[ ]	[ ]
Do you lose weight regularly to meet weight requirements for your sport?	[ ]	[ ]
14. Do you feel stressed out?	[ ]	[ ]
15. Do you, or someone in your family, have sickle cell trait or disease?	[ ]	[ ]

FEMALES ONLY

16. When was your first menstrual period? _____
When was your most recent menstrual period? _____
How much time do you usually have from the start of one period to the start of another? _____
How many periods have you had in the last year? _____
What was the longest time between periods in the last year?
Explain "Yes" answers here: _____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____

PARENT/GUARDIAN CONSENT FOR EMERGENCY MEDICAL ASSISTANCE

I hereby authorize _____ School District and its faculty members in charge of my child named below to obtain all necessary medical care for my child in the event that I cannot be reached to authorize it myself. I hereby authorize any licensed physician and/or medical personnel to render necessary medical treatment to my child.

Student's Name _____ Work Phone Number; Father _____

Address _____ Mother _____

_____ Home Phone Number _____

INSURANCE INFORMATION: Company _____ Policy # _____

Insured Person _____

Policy Holder's Social Security Number _____

Signature acknowledges that we have read and understand the above warning and we give consent for emergency assistance that might be needed.

Date _____ Signature of Parent/Guardian _____

WYOMING HIGH SCHOOL ACTIVITIES ASSOCIATION
SCHOOL PHYSICAL EXAMINATION
MEDICAL RECORD

PHYSICIANS STATEMENT MUST BE DATED AFTER MAY 1 TO BE VALID FOR THE UPCOMING SCHOOL YEAR

DATE OF EXAM _____

Name _____ Date of Birth _____

Height _____ Weight _____ % Body fat (optional) _____ Pulse _____ BP ____/____ (____/____, ____/____)

Vision R 20/_____ L 20/_____ Corrected: Y N Pupils: Equal _____ Unequal _____

	NORMAL	ABNORMAL FINDINGS
MEDICAL		
Appearance		
Eyes/Ears/Nose/Throat		
Lymph Nodes		
Heart		
Pulses		
Lungs		
Abdomen		
Genitalia (males only)		
Skin		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand		
Hip/thigh		
Knee		
Leg/ankle		
Foot		

*Normal indicated by check or N

[ ] **Cleared**

*[ ] **Cleared after completing evaluation/rehabilitation for:** _____

_____

_____

_____

*[ ] **Not cleared for:** _____ **Reason:** _____

Recommendations: _____

_____

_____

***IF THESE BOXES ARE CHECKED, A COPY OF THIS FORM NEEDS TO BE SENT TO THE APPROPRIATE SCHOOL DISTRICT.**

Name of physician (print/type) _____ **Date** _____

Address _____ **Phone** _____

Signature of physician _____, **MD or DO**

STUDENT/PARENT/GUARDIAN INFORMED CONSENT

Participation in all activities requires the acceptance of risk of possible serious injury. The risk can be minimized by following your coaches' rules and procedures, by familiarizing yourself with the rules of the activity, and by following the specific rules issued by manufacturers for the safe use of your activity equipment. The risk is always there, but you can help minimize it by making safety a shared responsibility. When you make the decision to participate in an activity, you are assuming the shared responsibility of following the activities rules, the coaches' rules, and the equipment manufacturer's rules. You, as a participant, can help make the activity safer by not intentionally using techniques which are illegal and which can cause serious injury.

Your signature below indicates that you have been informed about the importance of following rules in activities participation; and you realize that there is a risk of being injured that is inherent in all activities. You realize that the risk of injury may be severe, including the risk of fractures, brain injuries, paralysis or even death.

Activity programs specifically excluded: _____

Date _____ Signature of Student _____

Signature of Parent _____