Nay Ah Shing Schools
Enrollment Application

School Year ______________

For Office Use Only (date/initial)

Date of Records Request: ______________
Date Records Received: ______________
MARSS #: ______________
Copy of Tribal Enrollment: ______________
Copy of Birth Certificate: ______________
Copy of Immunization Record: ______________
School Board Approval: ______________

School Enrolling In: ○ Abinoojiiyag K-5 ____ Kindergarten Immersion ○ Nay Ah Shing 6-12 ○ Pine Grove K-6

School most recently attended by student: ______________ District ________ Grade Level: ________

Student Information

Full Legal Name	Ojibwe Name (if applicable)	Birthdate	Gender	Enrolling Grade
Address	**City**	**State**	**Zip Code**	
Tribal Affiliation	**Enrollment #**	**Ethnicity/Race** **Is your student Hispanic/Latino?** ○ Yes ○ No Ethnic Background (Mark all that apply)		
		○ American Indian or Alaska Native ○ Black or African American ○ Asian	○ Native Hawaiian or Pacific Islander ○ Hispanic/ Latino ○ White	

Parent/Guardian Info

Does the Parent/Guardian completing this form have physical and legal custody of the student? ○ Yes ○ No		If No, who has legal custody of student: ______________	
Student lives with: (mark all that apply)	○ Both Parents (in the same house) ○ Mother ○ Father ○ Grandparent	○ Mother and Stepparent ○ Father and Stepparent ○ Guardian ○ Foster Parent	○ Alone ○ Other (describe): ______________

Name Parent/Guardian 1	Relationship to Student	Primary Phone	Alternate Phone	Work Phone
Address		**City, State, Zip**	**Email**	
Name Parent/Guardian 2	**Relationship to Student**	**Primary Phone**	**Alternate Phone**	**Work Phone**
Address		**City, State, Zip**	**Email**	

Emergency Contacts

In case of an injury or illness, a parent/guardian or person designated by the parent/guardian will be notified. If we are unable to contact one of these people, the medical clinic clinic on record will be contacted. 9-1-1 will be called if it is necessary.

Emergency Contact 1 (other than those listed above)	Relationship to Student	Phone 1	Phone 2
Address:		City, State, Zip	

Emergency Contact 2 (other than those listed above)	Relationship to Student	Phone 1	Phone 2
Address:		City, State, Zip	

Siblings

Name	Gender	DOB	Grade	Live in the home?
	○ Male ○ Female			
	○ Male ○ Female			
	○ Male ○ Female			
	○ Male ○ Female			
	○ Male ○ Female			

Student Services

1. Does this student receive English Language Learner (ELL) services? ○ Yes ○ No
2. Does the student have a 504 Plan? ○ Yes ○ No
3. Does the student receive special education services (have an IEP)? ○ Yes ○ No

If yes, what is your student's disability? (mark all that apply)

○ Autism Spectrum Disorders (ASD)	○ Severely Multiply Impaired (SMI)
○ Developmental Cognitive Disability (DCD)	○ Emotional/Behavior Disorder (EBD)
○ Developmental Delay (DD)	○ Visually Impaired (VI)
○ Deaf-Hard of Hearing (DHH)	○ Physically Impaired (PI)
○ Deaf-Blind (DB)	○ Specific Learning Disability (SLD)
○ Speech/Language Impairments (S/LI)	○ Traumatic Brain Injury (TBI)
	○ Other Health Disabilities (OHD)

Signature/Consent

I, the parent/guardian for this student's enrollment/permanent record form, attest that the information included on this form is truthful and accurate. I understand access to information about my student is limited to Nay Ah Shing Staff whose work assignments reasonably require access to this data. I provide consent to Nay Ah Shing Schools to use my student's name, photo, video, and/or academic work for school/tribal publicity purposes which may include social media, television, and radio news. I understand that I have the right to revoke this consent at any time and, this right may be exercised pursuant to the instructions outlined in the HIPAA notice of Privacy Practices.

Printed Name	Date
Signature	

Nay Ah Shing Schools

Request for Student Records

Previous School Attended: ______________________________

Address: ______________________________

City ______________________________ State/Zip ______________________________

Phone #______________________________ Fax # ______________________________

______________________________ ______________________________ ______________
Student"s Name Date of Birth Grade

has enrolled in Nay Ah Shing Schools on ______________________________ and will start on ______________________________.

Please release the following information for this student.

Minnesota Statute 120A.22, Subdivision 7 Educational records; A district, charter school, or nonpublic school that receives services or aid under sections 123B.40 to 123B.48 from which a student is transferring must transmit the student's educational records within 10 business days of a request to the school in which the student is enrolling.

Copy of Birth Certificate

Health and Immunization Records

Special Education Information: IEP & Evaluation

Academic and Disciplinary Reports

Attendance Data

Other information which may be helpful for placement

Signature of Parent/Guardian ______________________________

Send Information to:

Registrar
Nay Ah Shing Schools
43561 Oodena Drive
Onamia, MN 56359
Phone: 320-532-4695
Fax: 320-532-4675

Nay Ah Shing Schools

Transportation Request

Transportation Director - Patti Wiersgalla * pwiersgalla@nas.k12.mn.us * (320) 674-0076

Student Name: ______________________ Grade ____________

Primary Address: ______________________________________

Parent/Legal Guardian Name: ______________________________

Contact Phone: ________________ email ________________

Work phone: ________________

Emergency Contact ________________ Phone ________________

Student will ride the bus (check one): Morning ________ Afternoon ________ Both ________

Students are allowed one stop location for pick-up and one stop location for drop-off, these locations may be different. Students are NOT allowed to have multiple pick-up and/or drop-off locations. Students will be allowed to have one alternative location.

AM Stop Location ________________ Address ________________

PM Stop Location ________________ Address ________________

Alternative Stop Location ________________ Address ________________

Parent/Guardian Signature ______________________ Date: ____________

BUS PASS requests are to be into the front office staff by 2:30pm each day.

Abinoojiiyag (320) 532 - 4690
Nay Ah Shing Middle/High School (320) 532 - 4695
Pine Grove (320) 384 - 6236

OMB Number: 1810-0021 Expiration Date: 07/31/2019

INSTRUCTIONS FOR THE ED 506 FORM

FOR APPLICANTS:

PURPOSE: To comply with the requirements in 20 USC 7427(a), which provides that: "The Secretary shall require that, as part of an application for a grant under this subpart, each applicant shall maintain a file, with respect to each Indian child for whom the local educational agency provides a free public education, that contains a form that sets forth information establishing the status of the child as an Indian child eligible for assistance under this subpart, and that otherwise meets the requirements of subsection (b)".

MAINTENANCE: A separate ED 506 form is required for each Indian child that was enrolled during the count period. A new ED 506 form does **NOT** have to be completed each year. All documentation must be maintained in a manner that allows the LEA to be able to discern, for any given year, which students were enrolled in the LEA's school(s) and counted during the count period indicated in the application.

FOR PARENTS/GUARDIANS:

DEFINITION: Indian means an individual who is (1) A member of an Indian tribe or band, as membership is defined by the Indian tribe or band, including any tribe or band terminated since 1940, and any tribe or band recognized by the State in which the tribe or band resides; (2) A descendant of a parent or grandparent who meets the requirements described in paragraph (1) of this definition; (3) Considered by the Secretary of the Interior to be an Indian for any purpose; (4) An Eskimo, Aleut, or other Alaska Native; or (5) A member of an organized Indian group that received a grant under the Indian Education Act of 1988 as it was in effect on October 19, 1994.

STUDENT INFORMATION: Write the name of the child, date of birth and school name and grade level.

TRIBAL ENROLLMENT INFORMATION: Write the name of the individual with the tribal membership. Only one name is needed for this section, even though multiple persons may have tribal membership. Select only one name: either the child, child's parent or grandparent, for whom you can provide membership information.

Write the name of the tribe or band of Indians to which the child claims membership. The name does not need to be the official name as it appears exactly on the Department of Interior's list of federally-recognized tribes, but the name must be recognizable and be of sufficient detail to permit verification of the eligibility of the tribe. Check only one box indicated whether it is a Federally Recognized, State Recognized, Terminated Tribe or Organized Indian Group. If Terminated Tribe or Organized Indian Group is elected, additional documentation is required and must be attached to this form.

- **Federally Recognized**- an American Indian or Alaska Native tribal entity limited to those indigenous to the U.S. The Department of Interior maintains a list of federally-recognized tribes, which OIE can provide you upon request.
- **State Recognized**- an American Indian or Alaska Native tribal entity that has recognized status by a State. The U.S. Department of Education does not maintain a master list. It is recommended that you use official state websites only.
- **Terminated Tribe**-a tribal entity that once had a federally recognized status from the United States Department of Interior and had that designation terminated.
- **Organized Indian Group**- Member of an organized Indian group that received a grant under the Indian Education Act of 1988 as it was in effect October 19, 1994.

Write the enrollment number establishing the membership of the child, if readily available, or other evidence of membership. If the child is not a member of the tribe and the child's eligibility is through a parent or grandparent, either write the enrollment number of the parent or grandparent, or provide other proof of membership. Some examples of other proof of membership may include: affidavit from tribe, CDIB card or birth certificate. Write the name and address of the organization that maintains updated and accurate membership data for such tribe or band of Indians.

ATTESTATION STATEMENT: Provide the name, address and email of the parent or guardian of the child. The signature of the parent or guardian of the child verifies the accuracy of the information supplied.

The Department of Education will safeguard personal privacy in its collection, maintenance, use and dissemination of information about individuals and make such information available to the individual in accordance with the requirements of the Privacy Act.

PAPERWORK BURDEN STATEMENT According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless such collection displays a valid OMB control number The valid OMB control number for this information collection is 1810-0021 The time required to complete this portion of the information collection per type of respondent is estimated to average: 15 minutes per Indian student certification (ED 506) form, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to U S Department of Education, Washington, D C 20202 4651. If you have comments or concerns regarding the status of your individual submission of this form, write directly to Office of Indian Education, U S. Department of Education, 400 Maryland Avenue, S W., LBJ/Room 3W203, Washington, D C. 20202-6335 OMB Number 1810-0021 Expiration Date 07/31/2019

OMB Number: 1810-0021 Expiration Date: 07/31/2019

U.S. Department of Education
Office of Indian Education
Washington, DC 20202

TITLE VI ED 506 INDIAN STUDENT ELIGIBILITY CERTIFICATION FORM

Parent/Guardian: This form serves as the official record of the eligibility determination for each individual child included in the student count. You are not required to complete or submit this form. However, if you choose not to submit a form, your child cannot be counted for funding under the program. **This form should be kept on file and will not need to be completed every year.** Where applicable, the information contained in this form may be released with your prior written consent or the prior written consent of an eligible student (aged 18 or over), or if otherwise authorized by law, if doing so would be permissible under the Family Educational Rights and Privacy Act, 20 U.S.C. § 1232g, and any applicable state or local confidentiality requirements.

STUDENT INFORMATION

Name of the Child ______________________ Date of Birth __________ Grade _____
(As shown on school enrollment records)

Name of School ____

TRIBAL ENROLLMENT

Name of the individual with tribal enrollment: ______________________________
(Individual named must be a descendent in the first or second generation)

The individual with tribal membership is the: _____ Child _____ Child's Parent _____ Child's Grandparent

Name of tribe or band for which individual above claims membership: ______________________

The Tribe or Band is (select only one):

_____ Federally Recognized
_____ State Recognized
_____ Terminated Tribe (Documentation required. Must attach to form)
_____ Member of an organized Indian group that received a grant under the Indian Education Act of 1988 as it was in effect October 19, 1994. (Documentation required. Must attach to form)

Proof of enrollment in tribe or band listed above, as defined by tribe or band is:

A. Membership or enrollment number (if readily available) ______________________ OR

B. Other Evidence of Membership in the tribe listed above (describe and attach) ______________

Name and address of tribe or band maintaining enrollment data for the individual listed above:

Name ______________________ Address ______________________

City ______________ State _____ Zip Code ________

ATTESTATION STATEMENT

I verify that the information provided above is accurate.

Name Parent/Guardian ______________________ Signature ______________________

Address ______________________ City ______________ State _____ Zip Code ________

Email Address ______________________ Date __________

MILLE LACS BAND OF OJIBWE

Enrollment Department

RELEASE OF INFORMATION

I, ________________(PARENT'S NAME), do hereby authorize the Mille Lacs Band of Ojibwe enrollment department to release information and records about my child ___________________________________(CHILD"S NAME) to (list people or institutions you want us to release to):

NAS School

I request the following to be released (list document or types of information you want released):

_X_ Enrollment Verification _X_ Birth Certificate _X_ Social Security #

Other:____

I understand that I can withdraw this consent in writing at any time. I am the individual, to whom the requested information or record applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare under penalty of perjury that I have examined all the information on this form, and any accompanying statements or forms, and it is true and correct to the best of my knowledge.

Signed: ______________________________ ____________________

Individual Date

____

Sign Name (parent of said minor)

Witnessed: ______________________________ ____________________

Witness Signature Date

____

Print Name

Nay Ah Shing Schools

Confidential Health Information Form

PRINT Student Name ______________________ DOB ____________ M ______ F ______

School Year ______________________ New Student __________ Returning Student __________

Parent/Guardian Consent for Release of Information:

The disclosure of health information within the school is limited to information necessary to serve the student's health and education interests. Your *voluntary* agreement gives permission for school staff to inform select school personnel (teacher, bus driver, nutrition, etc.), of precautions and procedures necessary to protect your child at school as well as allows the school to exchange student personal information with the providers listed below.

○ I AGREE ○ I DISAGREE Parent/Guardian Signature ______________________

Health Care Provider and Clinic ______________________

Dentist and Clinic ______________________

Eyecare Provider and Clinic ______________________

Does the student wear glasses/contacts? ______ YES ______ NO

Does the student wear hearing aids? ______ YES ______ NO

Your student's health history is important to provide the best care at school. It is the responsibility of the parent/guardian to notify the school of new or existing health concerns. If your student is prescribed medication or requires treatment at school, contact the school nurse and provide the medication or necessary equipment for use at school.

○ My child has no special health concern and does not require medication and treatment while in school.

○ YES, my child is diagnosed with a special health concern that may require routine or emergency medication and treatment while in school.

Check all that apply, and take the REQUIRED CARE PLAN to the medical provider to complete.

Asthma: Intermittent _____ Exercise Induced _____ Uses Inhaler _____

Diabetes: Type 1 ________ Type 2 ____________ Pump/Insulin _____

Student Name____________________________________

Medical History (check all that apply)

_____ Asthma	_____ Vision Problems	_____ Kidney/Bladder Problems
_____ Diabetes	_____ Hearing Problems	_____ Bleeding Disorder
_____ Heart Condition	_____ Dental Problems	_____ Menstrual Problems
_____ Seizures/Epilepsy	_____ Color Blindness	_____ Eczema
_____ Depression	_____ Frequent Nose Bleeds	_____ Anorexia/Bulimia
_____ Hyperactivity	_____ Frequent Stomach Aches	_____ Mental Health Diagnosis
_____ ADD/ADHD	_____ Frequent Headaches	_____ Emotional/Behavioral Concerns
_____ FAS/FAE	_____ Frequent Sore Throats	_____ Physical Handicap
_____ Speech Problems	_____ Orthopedic Conditions	_____ Concussion

If you marked any of the above, please explain ____

____

Immunizations

For the protection of all students, Minnesota State Law (M.S. 123.70) requires that all children who are enrolled in school be vaccinated against diphtheria, tetanus, pertussis, polio, measles, mumps, rubella, hepatitis B and varicella (Chicken Pox), allowing certain exemptions. Before students can attend school, each student must provide proof that the immunization schedule is in process or has been completed. Please include a copy of immunization records.

Medical and Authorizations Release

Authorization for emergency Medical Care and Medical Treatment. My child has permission to be administered minor first aid on school grounds during the school day by school personnel. In case a student becomes sick or injured during the school day, you will be notified. In the event that we are unable to reach you, we will attempt to contact persons listed as emergency contacts. If we can not contact you or the emergency contacts listed, we will be sure the student receives the needed medical attention. It is extremely important that you verify that we can take your child to the nearest hospital for medical attention. School personnel will accompany the student to the clinic until you or an emergency contact arrives. The school is in no way responsible for the medical bills incurred. I hereby authorize the medical providers at Ne-la-Shing Clinic or the nearest hospital to provide the necessary treatment to the student and release medical information as needed for insurance purposes.

_________Accept ________Decline _________Initials

Medication Administration

No medications, over-the-counter or prescribed, will be given to a student without proper written authorization. All medications taken during school hours must have a "Medication Administration Request" form completed and signed by parent/caregiver. For prescription medications, the form must be signed by parent/caregiver AND physician. All medication must be brought to the health office in its original container, labeled by a pharmacist in accordance with the law. Over-the-counter medications should be unopened and labeled with the student's name. All medication taken by students must be kept in the school nurse's office. Certain emergency medications may be carried and administered by a student after doctor, parent and school nurse approval.

Immunization Form

Name ________________ Birthdate ________________

Enter the dates for each vaccine your child has received to date. Specify the month, day, and year of each dose such as 01/01/2010.

Immunizations required for child care, early childhood programs, and school.

Vaccine	Birth to 6 months	12 -24 months	At Kindergarten	At 7th grade	At 12th grade
Hepatitis B					
Diphtheria, Tetanus, Pertussis (DTaP, DT, Td)					
Haemophilus influenzae type b (Hib)					
Pneumococcal (PCV)					
Polio					
Measles, Mumps, Rubella (MMR)					
Chickenpox (varicella)					
Hepatitis A					
Tetanus, Diphtheria, Pertussis (Tdap)					
Meningococcal (MCV4)					

Minnesota law requires children enrolled in child care, early childhood education, or school to be immunized against certain diseases, unless the child is medically or non-medically exempt.

Instructions for parent or guardian:

1. Fill out the dates in chronological order even if your child received a vaccine outside of the age/grade category that the box is in. Depending on the age of your child, they may not have received all vaccines; some boxes will be blank.
   - If you have a copy of your child's immunization history, you can attach a copy of it instead of completing the front of this form.
   - Your doctor or clinic can provide a copy of your child's immunization history. If you are missing or need information about your child's immunization history, talk to your doctor or call the Minnesota Immunization Information Connection (MIIC) at 651-201-3980 or 800-657-3970.
2. Sign or get the signatures needed for the back of this form.
   - Document medical and/or non-medical exemptions in section 1.
   - Verify history of chickenpox (varicella) disease in section 2.
   - Provide consent to share immunization information (optional) in section 3.

DEPARTMENT OF HEALTH
Immunization Program (2019)
www.health.state.mn.us/immunize

Instructions: Complete section 1 to document a medical or non-medical exemption, section 2 to verify history of varicella disease, and section 3 to consent to share immunization information.

Name ____________________

1. Document a medical and/or non-medical exemption (A and/or B).
Place an X in the box to indicate a medical or non-medical exemption. If there are exemptions to more than one vaccine, mark each vaccine with an X.

Vaccine	Medical Exemption	Non-Medical Exemption
Diphtheria, Tetanus, and Pertussis		
Polio		
Measles, Mumps, Rubella		
Haemophilus influenzae type b		
Chickenpox (varicella)		
Pneumococcal		
Hepatitis A		
Hepatitis B		
Meningococcal		

A. Medical exemption: By my signature below, I confirm that this child should not receive the vaccines marked with an X in the table for medical reasons (contraindications) or because there is laboratory confirmation that they are already immune.

Signature: ____________________ Date: __________
(of health care practitioner*)

B. Non-medical exemption: A child is not required to have an immunization that is against their parent or guardian's beliefs. However, choosing not to vaccinate may put the health or life of your child or others they come in contact with at risk. Unvaccinated children who are exposed to a vaccine-preventable disease may be required to stay home from child care, school, and other activities in order to protect them and others.

By my signature, I confirm that this child will not receive the vaccines marked with an X in the table because of my beliefs. I am aware that my child may be required to stay home from child care, school, and other activities if exposed.

Signature: ____________________ Date: __________
(of parent or guardian in presence of notary)

Non-medical exemptions must also be signed and stamped by a notary:

This document was acknowledged before me

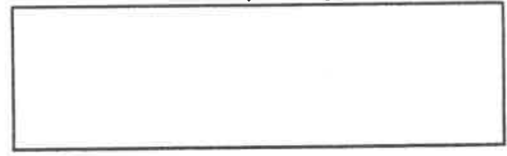
on __________ (date)

by ____________________
(name of parent or guardian)

Notary Signature:

____

Notary Stamp



STATE OF MINNESOTA, COUNTY OF

____

2. History of chickenpox (varicella) disease. This child had chickenpox in the month and year __________

My signature below means that I confirm that this child does not need chickenpox vaccine because:

☐ I am a health care practitioner and this child was previously diagnosed with chickenpox or the parent provided a description that indicates this child had chickenpox in the past.

☐ I am the parent or guardian and this child had chickenpox on or before September 1, 2010.

Signature: ____________________ Date: __________
(of health care practitioner*, representative of a public clinic, or parent/guardian). Parent can sign if chickenpox occurred before September 2010.

*Health care practitioner is defined as a licensed physician, nurse practitioner, or physician assistant.

3. Consent to share immunization information: This school is asking for permission to share your child's immunization record with Minnesota's immunization information system. Giving your permission will:

- Provide easier access for you and your school to check immunization records, such as at school entry each year.
- Support your school in helping to protect students by knowing who may be vulnerable to disease based on their immunization record. This can be important during a disease outbreak.

Under Minnesota law, all the information you provide is private and can only be released to those authorized to receive it. Signing this section of the form is optional. If you choose not to sign, it will not affect the health or educational services your child receives.

I agree to allow my child's school to share my child's immunization documentation with Minnesota's immunization information system:

Signature: ____________________ Date: __________
(of parent/guardian)

Family Food Allergy Health History Form

Student Name: ______________________ Date of Birth: __________

Parent/Guardian: ______________________ Today's Date: __________

Home Phone: __________ Work: __________ Cell: __________

Primary Healthcare Provider: ______________________ Phone: __________

Allergist: ______________________ Phone: __________

1. **Does your child have a diagnosis of an allergy from a healthcare provider:** ☐ No ☐ Yes

2. **History and Current Status**

a. What is your child allergic to?

☐ Peanuts	☐ Insect Stings
☐ Eggs	☐ Fish/Shellfish
☐ Milk	☐ Chemicals __________
☐ Latex	☐ Vapors __________
☐ Soy	☐ Tree Nuts (walnuts, pecans, etc.)
☐ Other: __________	

b. Age of student when allergy first discovered: __________

c. How many times has student had a reaction?
☐ Never ☐ Once ☐ More than once, explain: __________

d. Explain their past reaction(s): __________

e. Symptoms: __________

f. Are the food allergy reactions: ☐ Same ☐Better ☐ Worse

3. **Trigger and Symptoms**

a. What are the early signs and symptoms of your student's allergic reaction? *(Be specific; include things the student might say.)* __________

b. How does your child communicate his/her symptoms? __________

c. How quickly do symptoms appear after exposure to food(s)? _____secs. _____mins. _____hrs. _____days

d. Please check the symptoms that your child has experienced in the past:

Skin:	☐ Hives	☐ Itching	☐ Rash	☐ Flushing	☐ Swelling (face, arms, hands, legs)
Mouth:	☐ Itching	☐ Swelling (lips, tongue, mouth)			
Abdominal:	☐ Nausea	☐ Cramps	☐ Vomiting	☐ Diarrhea	
Throat:	☐ Itching	☐ Tightness	☐ Hoarseness	☐ Cough	
Lungs:	☐ Shortness of breath		☐ Repetitive Cough		☐ Wheezing
Heart:	☐ Weak pulse	☐ Loss of consciousness			

4. **Treatment**

a. How have past reactions been treated? __________

b. How effective was the student's response to treatment? __________

c. Was there an emergency room visit? ☐ No ☐ Yes, explain: __________

d. Was the student admitted to the hospital? ☐ No ☐ Yes, explain: __________

e. What treatment or medication has your healthcare provider recommended for use in an allergic reaction? __________

f. Has your healthcare provider provided you with a prescription for medication? ☐ No ☐ Yes

g. Have you used the treatment or medication? ☐ No ☐ Yes

h. Please describe any side effects or problems your child had in using the suggested treatment: __________

5. Self Care

a. Is your student able to monitor and prevent their own exposures? ☐ No ☐ Yes

b. Does your student:

1. Know what foods to avoid ☐ No ☐ Yes
2. Ask about food ingredients ☐ No ☐ Yes
3. Read and understands food labels ☐ No ☐ Yes
4. Tell an adult immediately after an exposure ☐ No ☐ Yes
5. Wear a medical alert bracelet, necklace, watchband ☐ No ☐ Yes
6. Tell peers and adults about the allergy ☐ No ☐ Yes
7. Firmly refuses a problem food ☐ No ☐ Yes

c. Does your child know how to use emergency medication? ☐ No ☐ Yes ____________

d. Has your child ever administered their own emergency medication? ☐ No ☐ Yes ____________

6. Family / Home

a. How do you feel that the whole family is coping with your student's food allergy? ____________

b. Does your child carry epinephrine in the event of a reaction? ☐ No ☐ Yes

c. Has your child ever needed to administer that epinephrine? ☐ No ☐ Yes

d. Do you feel that your child needs assistance in coping with his/her food allergy? ____________

7. General Health

a. How is your child's general health other than having a food allergy? ____________

b. Does your child have other health conditions? ____________

c. Hospitalizations? ____________

d. Does your child have a history of asthma? ☐ No ☐ Yes

If yes, does he/she have an Asthma Action Plan? ☐ No ☐ Yes

e. Please add anything else you would like the school to know about your child's health: ____________

____

8. Notes:

Parent / Guardian Signature: ____________ **Date:** ____________

Reviewed by R.N.: ____________ **Date:** ____________

Adapted with permission – Washington State Guidelines for Anaphylaxis