Tempe Union High School District
Request for Medical Documentation – Mental Health Concern

Student's Name:
Student ID:

Date:

Dear Parent/Guardian,

Attached are forms for your student for the upcoming school year. Forms are required each school year. The forms attached are:

1. Mental Health History form, to be filled out by the parent
2. Consent for Medication Administration Form, to be filled out by the parent and the licensed health care provider.

If you would like to request a meeting with the school Nurse regarding your student's health care needs, please let me know and I will arrange a meeting.

Please complete the Consent for Medication Administration Form if your student requires medication during the school day.

All completed paperwork and supplies needed to care for your student must be brought to school prior to your student's first day.

Feel free to contact your school health office with any questions.

Thank you,

Tempe Union High School District

MENTAL HEALTH HISTORY

Student Name ______________________________ DOB ______________

ID ______________________________ Date ______________

1. Has your student ever been diagnosed with a mental health condition? ○ No ○ Yes If yes, what is the diagnosis?

____

2. Has there been any hospitalization for this condition? ○ No ○ Yes If yes, provide details.

____

3. Is your student currently taking medication for this condition? ○ No ○ Yes If yes, list name, dosage, and how often your student takes this medication. **If the medication is to be kept in the health office, Consent for Medication Form must be on file.**

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4. Does your student suffer any side effects from these medications? ○ No ○ Yes If yes, explain.

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5. Does your student need special accommodations in the classroom? ○ No ○ Yes If yes, explain.

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6. Has your student's health care provider given any special orders due to his/her heart condition? ○ No ○ Yes

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7. Is there any other information about your child's condition you would like to share with school?

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8. When your student is experiencing a mental health crisis, what symptoms do they exhibit? (check once for any symptoms present, circle for major symptoms)

☐ Depressed mood ☐ Racing thoughts ☐ Excessive worry ☐ Unable to enjoy activities ☐ Impulsivity
☐ Anxiety attacks ☐ Sleep pattern disturbance ☐ Increase risky behavior ☐ Avoidance
☐ Loss of interest ☐ Increased libido ☐ Hallucinations ☐ Concentration/forgetfulness
☐ Decrease need for sleep ☐ Suspiciousness ☐ Change in appetite
☐ Excessive energy ☐ Excessive guilt ☐ Increased irritability ☐ Fatigue ☐ Crying
☐ Other ______________________

Parent/Guardian Signature ______________________________ Date ______________

TEMPE UNION HIGH SCHOOL DISTRICT

Consent for Giving Prescription and Non-Prescription Medications at School

School Year ________ to ________

Student Name ____

School ________________________________ **Student ID** ________________________

Medication must be delivered to school in the original container with the label intact.

The medication is to be given in the following manner:

Name of Medication: ____

Strength of Medication: ____

Amount to be Given: ____

Time of Administration at School: ____

Route of Administration (by mouth, etc.):_______________________________________

Comments and/or Instructions: ____

Reason for Medication: ____

Date Medication is to be discontinued: ____

☐ Student may self-carry and self-administer their medication (**Valid only for diabetes, asthma, and anaphylactic reactions. Students may not carry any other medications.**)

Healthcare Provider Name: __________________________ **Phone No.** __________________
(Please print)

____
Healthcare Provider Signature **Date**

I hereby request and my consent for the School Nurse or person designated by the School Administration to give my child medication prescribed by the below listed licensed health care provider. **I acknowledge that it may be necessary for the assistance in administration of medication to my child to be performed by an individual other than a nurse, and specifically consent to such practice.**

I understand the law provides that there shall be no liability for civil damages as a result of the assistance in administration of such medication and/or treatment where the person assisting in the administration of such medication and/or treatment acts as an ordinarily reasonably prudent person would under the same or similar circumstances. I understand my child's medication is to be presented to a school representative by an adult. I will assume full responsibility for the supply, appropriate transportation and maintenance of above medication. If any changes in medication or dosage occur, the school must be notified immediately, and a new form must be completed. I give permission for the exchange of information directly with the healthcare provider regarding my child's medication. **Any medications not picked up by the last day of school by the student's parent/guardian, or other designated adult, will be destroyed.**

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Parent/Guardian Home Phone # **Parent/Guardian Work Phone #**

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Parent/Guardian Signature **Date**