Adult Health and Emergency Form

Student Name: _____ **Class: _____**

If both parents (and/or an approved family member) plan to co-op in the classroom, one of these forms should be completed for each participating adult. This form MUST be on file at school before you participate in the classroom.

PART I: Parent Emergency Information: ***(YOU COMPLETE)***

Name: _____
Adult's Physician: _____
Physician Phone #: _____
List any allergies you have to food or medication:
_____

List any long-term medications you are taking:
_____

Any medical conditions we should know about?
_____

_____

Who should we contact if you experience a medical emergency? Please provide TWO contacts.

Name: _____ Daytime phone #: _____
Mobile phone #: _____

Name: _____ Daytime phone #: _____
Mobile phone #: _____

PART II: Tuberculin Screening ***(TO BE COMPLETED BY PHYSICIAN)***
State Licensing requires that participating adults submit documentation of a negative tuberculosis screening prior to entering the classroom. This may be in the form of (1) a letter from your physician or an official at the Health Department stating that a test was not deemed necessary; (2) results of a negative tuberculin skin test (TST); or (3) results of a chest x-ray negative for active tuberculosis disease. **If a test was not deemed necessary, please attach the letter from your physician to this form.** TST or chest x-ray results should be indicated below by physician.

- ❑ TB Screening documentation provided last school year.
- ❑ "Report of Tuberculosis Screening" completed and attached.

Name: _____

Date TST Administered: _____ Date of Reading: _____

PART III: Rubella Immunization ***(YOU MUST SIGN)***

All Spring-Mar students are required to provide a proof of immunization for polio, measles, rubella, diphtheria, pertussis, varicella, and tetanus before entering school. However, Spring-Mar honors formal petitions for waiver of these requirements for religious or medical reasons in accordance with the guidelines set by the Virginia State Department of Health.

This means that at some time there may be children in class who could contract these diseases. Other children and adults who are immunized are protected by their own immunizations, but it is crucial that women who are or may be pregnant be certain of their immunity to rubella (German Measles). Women may have their current level of immunity checked by a simple blood test known as the Rubella Titer. All responsible obstetricians require this of their patients, and your physician should certify these test results.

Please sign below to acknowledge your responsibility for current immunity to rubella.

I have read the above information and I assume responsibility for my own current immunity:

Signed: _____

Print name: _____

Date: _____

PART IV: COVID-19 Vaccination Verification ***(YOU COMPLETE)***

In an effort to guard against the possibility of a COVID-19 outbreak at Spring-Mar and its potential consequences, we have made the decision to require all faculty, staff, and parents/adults serving in a co-oping role to be fully vaccinated against the COVID-19 virus, plus any recommended boosters, by the start of the 2022-2023 school year.

- ☐ By checking this box and signing below, I attest that I am fully vaccinated against COVID-19 (including any recommended boosters).
- ☐ I have provided a copy of my COVID-19 Vaccination Record Card or electronic vaccination record.

Signed: _____

Print name: _____

Date: _____

Received by: _____

Date: _____

REPORT OF TUBERCULOSIS SCREENING
CHILD DAY PROGRAMS

Standards and child care policy require certain individuals to submit a report indicating the absence of tuberculosis in a communicable form when involved with child day programs and family day systems regulated by the Department of Education, including unlicensed, unregistered programs that participate in the Child Care Subsidy Program. Each report must be dated and signed by the examining physician, the physician's designee, or an official of a local health department. When signed by the physician's designee, the form must also identify the physician/physician practice with which the physician–designated screener is affiliated.

Name: _____ Date of Birth: _____

Address (Street, City, State, Zip Code): _____
_____

1). ____ A tuberculin skin test (PPD) is not indicated at this time due to the absence of symptoms suggestive of active tuberculosis, risk factors for developing active TB or known recent contact exposure.

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2).

Tuberculin Skin Test (PPD): Date given: _____ Date read: _____

Results: _____ mm Positive: _____ Negative: _____

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3). ____ The individual has a history of a positive tuberculin skin test (latent infection). Follow-up chest x-ray is not needed at this time due to the absence of symptoms suggestive of active tuberculosis.

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4). ____ The individual either is currently receiving or has completed medication for a positive tuberculin skin test (latent TB infection) and a chest x-ray is not indicated at this time. The individual has no symptoms suggestive of active tuberculosis disease.

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5). ____ The individual had a chest x-ray on _____ (date) at _____ _____(location) that showed no evidence of active tuberculosis. Based on this chest x-ray and the absence of symptoms suggestive of active tuberculosis disease, a repeat film is not indicated at this time.

Based on the available information, the individual can be considered free of tuberculosis in a communicable form.

Signature/Title: _____ Date: _____
(MD/designee or Health Department Official)

_____
(Print Name/Title)

Address, including name of practice if appropriate

_____

_____

_____

Phone number

_____