Appendix B: Health Forms and Documentation

Universe International School (UIS), Erbil

Student Health Forms, Medication Administration Forms, and Incident Report Forms

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1. STUDENT HEALTH FORMS

1.1 Student Health Information Form

CONFIDENTIAL - STUDENT HEALTH RECORD

Student Information:

- Student Name: _____
- Date of Birth: _____ Age: _____ Grade: _____
- Student ID Number: _____
- Emergency Contact: _____
- Phone Number: _____

Parent/Guardian Information:

- Primary Guardian: _____
- Relationship: _____
- Home Phone: _____ Work Phone: _____
- Cell Phone: _____ Email: _____
- Secondary Guardian: _____
- Relationship: _____
- Contact Numbers: _____

Medical Information: Does your child have any of the following conditions? (Check all that apply)

CONDITION	YES	NO	DETAILS/SEVERITY
Allergies (Food)	☐	☐	
Allergies (Environmental)	☐	☐	
Allergies (Medication)	☐	☐	
Asthma	☐	☐	
Diabetes	☐	☐	
Epilepsy/Seizures	☐	☐	
Heart Condition	☐	☐	
Blood Disorders	☐	☐	
Vision Problems	☐	☐	
Hearing Problems	☐	☐	
Learning Disabilities	☐	☐	
ADHD/ADD	☐	☐	
Autism Spectrum Disorder	☐	☐	
Physical Disabilities	☐	☐	
Mental Health Conditions	☐	☐	
Other Chronic Conditions	☐	☐	

Detailed Medical History:

- Previous Hospitalizations: _____
- Previous Surgeries: _____
- Current Medications: _____
- Dosage and Schedule: _____
- Medication Allergies: _____
- Emergency Medications (EpiPen, Inhaler, etc.): _____

Emergency Medical Information:

- Primary Physician: _____
- Phone Number: _____
- Clinic/Hospital: _____
- Preferred Hospital: _____
- Insurance Provider: _____
- Policy Number: _____

Immunization Record:

VACCINE	DATE RECEIVED	BOOSTER DUE
DPT/DTaP		
MMR		
Polio		
Hepatitis B		
Varicella (Chickenpox)		
Tuberculosis Test		
COVID-19		
Other: _____		

Physical Activity Restrictions: ☐ No restrictions ☐ Limited physical activity: _____ ☐ No contact sports ☐ Other restrictions: _____

Dietary Restrictions/Allergies: ☐ No dietary restrictions ☐ Food allergies: _____ ☐ Religious dietary requirements: _____ ☐ Medical dietary restrictions: _____

Parent/Guardian Signature: _____ **Date:** _____

School Nurse Review: Date Reviewed: _____ **Nurse Signature:** _____ **Action Plan Required:** ☐ Yes ☐ No **Follow-up Needed:** _____

1.2 Emergency Medical Authorization Form

EMERGENCY MEDICAL CARE AUTHORIZATION

Student: _____ **Grade:** ____ **Date of Birth:** _____ **School Year:** _____

EMERGENCY CONTACT INFORMATION:

Primary Contact:

- Name: _____
- Relationship: _____
- Phone (Home): _____ (Work): _____
- Cell: _____ Email: _____

Secondary Contact:

- Name: _____
- Relationship: _____
- Phone (Home): _____ (Work): _____

- Cell: _____ Email: _____

Medical Information:

- Family Physician: _____
- Phone: _____
- Preferred Hospital: _____
- Insurance Company: _____
- Policy Number: _____

MEDICAL AUTHORIZATION: I hereby authorize Universe International School staff to:

☐ Administer basic first aid treatment
☐ Contact emergency medical services if needed
☐ Transport my child to the nearest medical facility
☐ Authorize emergency medical treatment if I cannot be reached

Special Medical Conditions/Medications:

_____

_____

Medications to AVOID:

_____

I understand that:

- School staff will make every effort to contact me before seeking medical care
- In case of serious emergency, paramedics will be called immediately
- School staff are not medical professionals and will use reasonable judgment
- I am responsible for all medical expenses incurred

Parent/Guardian Signature: _____ Date: _____ Witness: _____

ANNUAL UPDATE REQUIRED

1.3 Health Assessment and Screening Form

ANNUAL HEALTH ASSESSMENT

Student: _____ Date: _____ Grade: ____ School Nurse: _____

Physical Measurements:

- Height: _____ Weight: _____ BMI: _____
- Blood Pressure: _____ Pulse: _____
- Temperature: _____ Respirations: _____

Vision Screening:

- Right Eye: 20/_____ Left Eye: 20/_____ Both Eyes: 20/_____
- Color Vision: ☐ Normal ☐ Abnormal
- Referral Needed: ☐ Yes ☐ No

Hearing Screening:

- Right Ear: ☐ Pass ☐ Fail Left Ear: ☐ Pass ☐ Fail
- Referral Needed: ☐ Yes ☐ No

Dental Screening:

- Oral Health: ☐ Good ☐ Fair ☐ Poor
- Dental Referral Needed: ☐ Yes ☐ No

Immunization Status:

- Up to Date: ☐ Yes ☐ No
- Missing: _____

Health Concerns Identified:

_____

_____

Recommendations:

- Dietary: _____
- Physical Activity: _____
- Medical Follow-up: _____
- Other: _____

Nurse Signature: _____ **Date:** _____

Parent Notification: ☐ Sent ☐ N/A **Follow-up Required:** ☐ Yes ☐ No

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2. MEDICATION ADMINISTRATION FORMS

2.1 Medication Administration Authorization

MEDICATION ADMINISTRATION REQUEST

Student Information:

- Name: _____
- Grade: _____ Teacher: _____

- Date of Birth: _____

Prescribing Physician Information:

- Physician Name: _____
- Phone Number: _____
- Date Prescribed: _____

Medication Information:

- Medication Name: _____
- Strength/Dosage: _____
- Route of Administration: ☐ Oral ☐ Topical ☐ Inhaled ☐ Injection
- Time(s) to be Given: _____
- Duration of Treatment: _____
- Reason for Medication: _____

Special Instructions:

- Food Requirements: ☐ With food ☐ Without food ☐ No restriction
- Storage Requirements: ☐ Room temperature ☐ Refrigerated
- Side Effects to Monitor: _____
- Emergency Instructions: _____

PHYSICIAN AUTHORIZATION: I certify that this student requires the above medication during school hours and authorize trained school personnel to administer this medication as prescribed.

Physician Signature: _____ Date: _____ License #: _____

PARENT/GUARDIAN AUTHORIZATION: I request that school personnel administer the above medication to my child and:

- Understand that school personnel are not medical professionals
- Will provide all medications in original pharmacy containers
- Will notify school of any changes in medication
- Release the school from liability for adverse reactions from properly administered medication

Parent/Guardian Signature: _____ Date: _____

SCHOOL NURSE REVIEW: ☐ Medication received in original container with pharmacy label ☐ Instructions clear and complete ☐ Storage requirements noted ☐ Student instructed on self-administration if appropriate

Nurse Signature: ____________________ **Date:** _____

2.2 Daily Medication Administration Log

DAILY MEDICATION LOG

Student: __________________________ **Month/Year:** ______ **Medication:** _________________________
Dosage: _________

DATE	TIME	DOSE GIVEN	STAFF INITIALS	STUDENT RESPONSE	NOTES
		☐ Yes ☐ No ☐ Refused		☐ Normal ☐ Adverse	
		☐ Yes ☐ No ☐ Refused		☐ Normal ☐ Adverse	
		☐ Yes ☐ No ☐ Refused		☐ Normal ☐ Adverse	
		☐ Yes ☐ No ☐ Refused		☐ Normal ☐ Adverse	
		☐ Yes ☐ No ☐ Refused		☐ Normal ☐ Adverse	
		☐ Yes ☐ No ☐ Refused		☐ Normal ☐ Adverse	
		☐ Yes ☐ No ☐ Refused		☐ Normal ☐ Adverse	
		☐ Yes ☐ No ☐ Refused		☐ Normal ☐ Adverse	
		☐ Yes ☐ No ☐ Refused		☐ Normal ☐ Adverse	
		☐ Yes ☐ No ☐ Refused		☐ Normal ☐ Adverse	

MEDICATION TRACKING:

- Starting Quantity: ______ Ending Quantity: ______
- Doses Given: ______ Doses Missed: ______
- Refill Needed: ☐ Yes ☐ No Date Needed: ________

ADVERSE REACTIONS/CONCERNS:

PARENT NOTIFICATION LOG:

DATE	REASON	METHOD	STAFF
		☐ Phone ☐ Email ☐ Note	
		☐ Phone ☐ Email ☐ Note	

School Nurse Signature: ______________________ **Date:** ______

2.3 Emergency Medication Action Plan

EMERGENCY MEDICATION ACTION PLAN

Student: _____ **Photo →** [ ] **Condition:** _____ **Grade:** ____

Teacher: _____

EMERGENCY CONTACT:

- Parent/Guardian: _____
- Phone: _____
- Emergency Contact: _____
- Phone: _____

MEDICAL EMERGENCY INFORMATION: Type of Emergency: ☐ Severe Allergic Reaction ☐ Asthma Attack ☐ Seizure ☐ Diabetic Emergency ☐ Other: _____

WARNING SIGNS TO WATCH FOR:

_____

_____

EMERGENCY MEDICATION:

- Medication Name: _____
- Location: _____
- Dosage: _____
- Administration Method: _____

STEP-BY-STEP EMERGENCY PROCEDURES:

STEP 1: _____ **STEP 2:** _____ **STEP 3:** _____ **STEP 4:** Call 911 if: _____ **STEP 5:** Contact parent/guardian immediately

FOLLOW-UP CARE:

_____

DO NOT:

_____

ADDITIONAL NOTES:

_____

Physician Signature: _____ **Date:** _____ **Parent Signature:** _____

School Nurse: _____

STAFF TRAINING COMPLETED:

STAFF NAME	POSITION	TRAINING DATE	SIGNATURE

ANNUAL REVIEW REQUIRED

_____

3. INCIDENT REPORT FORMS

3.1 Student Injury/Incident Report Form

STUDENT INJURY/INCIDENT REPORT CONFIDENTIAL

Report Number: _____ Date of Report: _____ Reported by: _____ Time: _____

STUDENT INFORMATION:

- Name: _____
- Grade: ____ Teacher: _____
- Age: ____ Date of Birth: _____
- Parent/Guardian: _____
- Contact Phone: _____

INCIDENT DETAILS:

- Date of Incident: _____
- Time of Incident: _____
- Location: _____
- Weather Conditions (if outdoor): _____

TYPE OF INCIDENT: (Check all that apply) ☐ Fall ☐ Collision ☐ Cut/Laceration ☐ Burn ☐ Bite ☐ Sports Injury ☐ Playground Injury ☐ Transportation Incident ☐ Allergic Reaction ☐ Medical Emergency ☐ Behavioral Incident ☐ Other: _____

BODY PART INJURED: ☐ Head ☐ Neck ☐ Back ☐ Chest ☐ Abdomen ☐ Right Arm ☐ Left Arm ☐ Right Leg ☐ Left Leg ☐ Hand ☐ Foot ☐ Face ☐ Eyes ☐ Teeth ☐ Other: _____

DESCRIPTION OF INCIDENT:

_____
_____
_____
_____

APPARENT CAUSE OF INCIDENT:

_____
_____

WITNESSES:

1. Name: _____ Position: _____
2. Name: _____ Position: _____
3. Name: _____ Position: _____

IMMEDIATE CARE PROVIDED: ☐ No treatment needed ☐ First aid administered ☐ Ice applied ☐ Bandage applied ☐ Cleaned wound ☐ Other: _____

CARE PROVIDED BY:

- Name: _____
- Position: _____
- Certification: _____

STUDENT'S RESPONSE TO TREATMENT: ☐ No complaints ☐ Continued pain ☐ Improved ☐ Worsened ☐ Refused treatment ☐ Other: _____

PARENT NOTIFICATION:

- Time Parent Called: _____
- Spoke with: _____
- Parent Response: _____
- Student Released to: _____
- Time: _____

MEDICAL ATTENTION: ☐ No medical attention needed ☐ Recommended to see doctor ☐ Sent to school nurse ☐ Called paramedics ☐ Transported to hospital ☐ Parent took to doctor

FOLLOW-UP REQUIRED: ☐ None ☐ Monitor tomorrow ☐ Physician clearance needed ☐ Return to activity restrictions ☐ Equipment inspection ☐ Other: _____

PREVENTION MEASURES:

_____

_____

Report Completed by: _____ **Signature:** _____ **Date:** _____

Supervisor Review: _____ **Signature:** _____ **Date:** _____

Parent Acknowledgment: _____ **Signature:** _____ **Date:** _____

3.2 Staff Injury/Incident Report Form

STAFF INJURY/INCIDENT REPORT

Report Number: _____ **Date of Report:** _____

EMPLOYEE INFORMATION:

- Name: _____
- Position: _____

- Department: _____
- Supervisor: _____
- Employee ID: _____

INCIDENT DETAILS:

- Date of Incident: _____
- Time of Incident: _____
- Location: _____
- Shift: _____

TYPE OF INCIDENT: ☐ Slip/Fall ☐ Lifting Injury ☐ Cut/Laceration ☐ Burn ☐ Motor Vehicle ☐ Violence/Assault ☐ Chemical Exposure ☐ Repetitive Motion ☐ Struck by Object ☐ Equipment Malfunction ☐ Other: _____

BODY PART(S) AFFECTED: ☐ Head ☐ Neck ☐ Back ☐ Shoulder ☐ Arm ☐ Wrist ☐ Hand ☐ Leg ☐ Knee ☐ Ankle ☐ Foot ☐ Multiple Areas ☐ Other: _____

DESCRIPTION OF INCIDENT:

_____

_____

_____

FACTORS CONTRIBUTING TO INCIDENT: ☐ Inadequate training ☐ Equipment malfunction ☐ Unsafe condition ☐ Failure to follow procedure ☐ Inadequate PPE ☐ Time pressure ☐ Environmental factors ☐ Other: _____

WITNESSES:

1. _____
2. _____

IMMEDIATE ACTIONS TAKEN: ☐ First aid administered ☐ Medical attention sought ☐ Area secured ☐ Equipment taken out of service ☐ Supervisor notified ☐ Other: _____

MEDICAL TREATMENT: ☐ No treatment needed ☐ First aid only ☐ Clinic visit ☐ Emergency room ☐ Hospital admission ☐ Physician visit ☐ Other: _____

WORK STATUS: ☐ Returned to full duty ☐ Light duty ☐ Time off work ☐ Medical evaluation pending

CORRECTIVE ACTIONS RECOMMENDED:

_____

_____

Employee Signature: _____ **Date:** _____ **Supervisor Signature:** _____ **Date:** _____

_____

3.3 Visitor/Volunteer Incident Report

VISITOR/VOLUNTEER INCIDENT REPORT

Report Date: _____ **Report Number:** _____

VISITOR/VOLUNTEER INFORMATION:

- Name: _____
- Address: _____
- Phone: _____
- Purpose of Visit: _____
- Authorized by: _____

INCIDENT INFORMATION:

- Date: _____ Time: _____ Location: _____
- Type of Incident: _____
- Injuries Sustained: _____

INCIDENT DESCRIPTION:

_____

_____

IMMEDIATE RESPONSE: ☐ First aid provided ☐ Emergency services called ☐ Medical facility transport ☐ Released to family ☐ No treatment needed

WITNESSES:

_____

FOLLOW-UP ACTIONS:

_____

Report Completed by: _____ **Signature:** _____ **Date:** _____

_____

4. SPECIALIZED HEALTH FORMS

4.1 Food Allergy Management Plan

FOOD ALLERGY ACTION PLAN

Student: _____ **Photo** → [ ] **Allergens:** _____

EMERGENCY CONTACTS:

- Parent/Guardian: _____
- Phone: _____

- Physician: _____
- Phone: _____

ALLERGY SYMPTOMS: Mild-Moderate Reaction: ☐ Mouth: itching, tingling ☐ Skin: hives, itchy rash ☐ Gut: nausea, cramps, diarrhea **Actions:** _____

Severe Reaction (ANAPHYLAXIS): ☐ Trouble breathing ☐ Swelling of face/throat ☐ Severe whole body reaction ☐ Dizziness, confusion ☐ Rapid pulse ☐ Loss of consciousness

EMERGENCY TREATMENT:

1. Give epinephrine immediately
2. Call 911
3. Contact parents
4. Give second dose if no improvement in 5-15 minutes

EPINEPHRINE LOCATION:

- Location 1: _____
- Location 2: _____

DAILY MANAGEMENT: ☐ No food sharing ☐ Wash hands before eating ☐ Wipe down eating surfaces ☐ Read all food labels ☐ Trained staff supervision during meals

Physician Signature: _____ **Parent Signature:** _____ **Date:** _____ **Review Date:** _____

4.2 Asthma Action Plan

ASTHMA ACTION PLAN

Student: _____ **Photo** → [ ] **Grade:** ____ **Teacher:** _____

EMERGENCY CONTACTS:

- Parent: _____
- Phone: _____
- Doctor: _____
- Phone: _____

DAILY MEDICATIONS:

- Medicine: _____
- How Much: _____

- When: _____

QUICK-RELIEF MEDICINE:

- Medicine: _____
- How Much: _____
- When: _____

GREEN ZONE - GOOD CONTROL: ☐ No symptoms ☐ Can do normal activities **Action:** Continue daily medicine

YELLOW ZONE - CAUTION: ☐ Cough ☐ Wheeze ☐ Chest tight ☐ Short of breath **Action:** Give quick-relief medicine, rest, notify parent

RED ZONE - EMERGENCY: ☐ Very short of breath ☐ Can't walk/talk normally ☐ Lips/fingernails blue ☐ Ribs showing when breathing **Action:** Give quick-relief medicine immediately, call 911

INHALER LOCATION:

- Student carries: ☐ Yes ☐ No
- Office location: _____
- Classroom location: _____

ACTIVITY RESTRICTIONS: ☐ No restrictions ☐ Pre-medicate before exercise ☐ Avoid specific triggers: _____

Physician Signature: _____ **Parent Signature:** _____ **Date:** _____ **Review Date:** _____

4.3 Seizure Action Plan

SEIZURE ACTION PLAN

Student: _____ **Photo** → [ ] **Type of Seizures:** _____

SEIZURE DESCRIPTION:

_____
_____

TYPICAL DURATION: _____ **FREQUENCY:** _____

SEIZURE RESPONSE PROCEDURES: DURING SEIZURE:

1. Stay calm and time the seizure
2. Keep student safe - clear area of hard objects
3. Do not put anything in mouth

4. Turn on side if possible
5. Do not restrain

AFTER SEIZURE:

1. Check for injuries
2. Allow rest period
3. Provide reassurance
4. Monitor for additional seizures

CALL 911 IF: ☐ Seizure lasts longer than _____ minutes ☐ Student is injured during seizure ☐ Student has difficulty breathing after seizure ☐ Another seizure begins before recovery ☐ Student requests emergency medical care

RECOVERY INFORMATION:

- Typical recovery time: _____
- Common post-seizure symptoms: _____
- Return to activity: _____

MEDICATIONS:

- Emergency medication: _____
- Location: _____
- When to give: _____

PARENT NOTIFICATION: ☐ Call immediately ☐ Call if seizure unusual ☐ Send note home

Physician Signature: _____ **Parent Signature:** _____ **Date:** _____ **Review Date:** _____

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5. HEALTH DOCUMENTATION PROCEDURES

5.1 Health Record Maintenance Log

STUDENT HEALTH RECORD MAINTENANCE

Student: _____ **Grade:** _____ **School Year:** _____

DOCUMENT CHECKLIST: ☐ Health Information Form (current year) ☐ Emergency Medical Authorization ☐ Immunization Records (up to date) ☐ Physical Examination (if required) ☐ Medication Authorization Forms ☐ Individual Health Care Plan (if needed) ☐ Emergency Action Plans (if applicable)

UPDATES RECEIVED:

DATE	DOCUMENT TYPE	UPDATED BY	FILED BY

PARENT COMMUNICATIONS:

DATE	TYPE	REASON	RESPONSE
	☐ Phone ☐ Email ☐ Letter		
	☐ Phone ☐ Email ☐ Letter		

ANNUAL REVIEW:

- Date Completed: _____
- Forms Updated: _____
- Follow-up Needed: _____

Maintained by: _____ Date: _____

5.2 Confidentiality and Access Log

HEALTH RECORD ACCESS LOG

Student: _____ Record ID: _____

DATE	TIME	PERSON ACCESSING	POSITION	REASON	SIGNATURE

AUTHORIZED PERSONNEL:

- School Nurse: _____
- Principal: _____
- Assistant Principal: _____
- Teachers (with health-related need): _____
- Other: _____

RELEASE OF INFORMATION:

DATE	INFORMATION RELEASED TO	PURPOSE	PARENT CONSENT
			☐ Yes ☐ No
			☐ Yes ☐ No

PRIVACY BREACH INCIDENTS:

- Date: _____
- Description: _____

- Corrective Action: _____
- Reported to: _____

5.3 Document Retention Schedule

HEALTH DOCUMENT RETENTION POLICY

DOCUMENT TYPE	RETENTION PERIOD	DISPOSITION
Student Health Forms	3 years after graduation	Destroy/Return to parent
Immunization Records	Permanent	Transfer to new school
Medication Records	3 years after last dose	Destroy confidentially
Incident Reports	7 years	Destroy confidentially
Individual Health Plans	Until graduation + 3 years	Destroy confidentially
Emergency Action Plans	Until plan expires	Update annually

ANNUAL RECORD REVIEW:

- Review Date: _____
- Records Purged: _____
- New Storage Method: _____
- Completed by: _____

TRANSFER PROCEDURES: Student Transferring TO UIS: ☐ Request records from previous school ☐ Review for completeness ☐ Update emergency contacts ☐ Schedule health screening if needed

Student Transferring FROM UIS: ☐ Prepare record summary ☐ Include current medications ☐ Send immunization records ☐ Forward emergency plans

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Document Control Information

Prepared by: School Health Services, Universe International School **Reviewed by:** School Nurse, Principal, Legal Counsel **Approved by:** Board of Directors **Effective Date:** [Date] **Review Cycle:** Annual **Distribution:** Health Office, Administrative Office, Teachers (relevant forms)

Forms Available in Multiple Languages:

- English ✓
- Arabic ✓
- Kurdish ✓
- Additional languages upon request

Training Requirements:

- All staff handling health information must complete HIPAA training
- Annual review of confidentiality procedures required
- New staff orientation includes health documentation procedures

Contact Information:

- School Nurse: health@uis-erbil.edu | [Phone]
- Health & Safety Officer: safety@uis-erbil.edu | [Phone]
- Administrative Office: admin@uis-erbil.edu | [Phone]

All health forms and documentation must be completed accurately and maintained confidentially in accordance with applicable privacy laws and school policies. For questions about health documentation requirements, contact the school health office.