Student Health Services Handbook
2023-2024

Board of Education Approved:

LOWNDES COUNTY SCHOOL BOARD

The Board of Education meets on the second Friday of each month at 12:30 p.m. The meeting is held in the board room of the Superintendent's Office, 1053 Highway 45 South, Columbus, MS 39701 (244-5000). Members of the board are:

Brad Fleming	Robert Barksdale, President	Wesley Barrett, Secretary
Jacqueline Gray	Jane Kilgore, Vice President	Jeff Smith, Attorney

CENTRAL OFFICE ADMINISTRATION

Sam Allison, Superintendent----------244-5005
Stefanie Jones, Assistant Superintendent----------244-5019
Matt Keith, Assistant Superintendent----------244-5027
Sayonia Garvin, Business Office Administrator----------244-5016
Jeanise Andrews, Technology Coordinator ----------244-5018
Dr. Christy Adams, Curriculum Coordinator ----------244-5007
Veronica Hill, Human Resources----------244-5010
Kristie Jones, Federal Programs Director ----------244-5030
Rhonda Locke, Special Education Director ----------244-5024

SUPPORT STAFF

Andrew Matthews, Director of Child Nutrition ----------244-5021
Greg Wheat, Maintenance Supervisor ----------434-6123
Dennis Aldridge, Transportation Supervisor----------434-6299
Roger Gaudet, Network Manager ----------244-5006

LOWNDES COUNTY SCHOOL DISTRICT SCHOOLS

Caledonia Elementary School (K-5) ---------- Roger Hill, Principal
9509 Wolfe Road, Caledonia, MS 39740 ----------Phone 356-2050-Fax 356-2065

Caledonia Middle School (6-8)----------Jeannie Jernigan, Principal
105 Confederate Drive, Caledonia, MS 39740 ---------- Phone 356-2042– Fax 356-2045

Caledonia High School (9-12) ----------Gregory Elliott, Principal
111 Confederate Drive, Caledonia, MS 39740 ---------- Phone 356-2001– Fax 356-2036

New Hope Elementary School (K-5) ----------Angela Wilcox, Principal
199 Enlow Drive, Columbus, MS 39702----------Phone 244-4760-Fax 244-4775

New Hope Middle School (6-8) ---------- Eric Guerrero, Principal
3419 New Hope Road, Columbus, MS 39702----------Phone 244-4740– Fax 244-4758

New Hope High School (9-12) ---------- Matthew Smith, Principal
2920 New Hope Rd, Columbus, MS 39702---------- Phone 244-4701– Fax 244-4725

West Lowndes Elementary School (K-6) ---------- Robert Sanders, Principal
1000 Gilmer-Wilburn Road, Columbus, MS 39701 ---------- Phone 244-5050 –Fax 328-2912

West Lowndes Highs School (7-12) ---------- Antonio Magee, Principal
644 South Frontage Road, Columbus, MS 39701 ---------- Phone 244-5070 – Fax 327-3353

Alternative School---------- Dr. Aaron Lee, Principal
3419 New Hope Road, Columbus, MS 39702---------- Phone 244-5060 Fax 327-4857

Career & Technical Center----------Susan Lingle McClelland, Director
1085 Lehmberg Road, Columbus, MS 39702 ----------Phone 244-5038 Fax 240-4108

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Lowndes County School District
School Nurses Contacts

New Hope Campus

Tina Moore	(662) 244-4774
Kim Woodruff	(662) 244-4776
Morgan Thomas	(662) 244-4748

Caledonia Campus

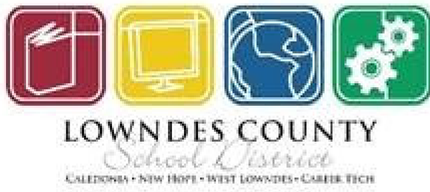
Casey Clark	(662) 356-2056
Katie Elliott	(662) 356-2048
Shelley McGlothin	(662) 356-2015

West Lowndes Elementary

Catherine Gilkey	(662) 244-5056

West Lowndes High

Cortney Merchant (662)-244-5075



The policies and procedures in this booklet are the result of a concerted effort on the part of the nurses and administration of the Lowndes County School District to inform students, parents, teachers and administrators. This information has been carefully prepared and reviewed to ensure that the medical needs of the students in the District are met with urgency and care.

Please immediately notify a nurse, teacher, or school administrator of your child's medical needs as soon as possible. Once the nurse has the appropriate information and documentation, she can begin to assist your child with their medical needs during the school day.

VISION

Provide a superior educational system that challenges all students to attain their greatest intellectual, social, and personal potential.

MISSION

Challenge all students to attain their greatest potential.

BELIEFS

- Students learn best when they are actively engaged in a challenging learning process.
- A safe and physically comfortable environment promotes student learning.
- All students in our school need to have an equal opportunity to learn.
- Teachers, administrators, parents and the community share the responsibility for helping students learn.
- Interactions with adults and other students contribute to student learning.
- A student's performance is enhanced by mutual respect among students and staff.
- Students learn best when our staff maintains high expectations for learning.
- Motivation to learn is influenced by a student's emotional state, beliefs, interests, goals, and habits of thinking.
- Exceptional students (e.g., special education, limited English proficiency, talented and gifted, etc.) need special services and resources to improve their performance.
- Students learn more when provided with a variety of challenging instructional approaches.

District: Lowndes County School District
Section: J- Students
Policy Code: JGCB- Student Health Services Inoculations Policy

INOCULATIONS

This school board has power, authority, and duty to require those vaccinations specified by the state health officer as provided in Section 41 23 37. `37 7 301 (i).

Whenever indicated, the state health officer shall specify immunization practices that are considered best for the control of vaccine preventable diseases. A listed shall be promulgated annually or more often, if necessary.

Expect as provided hereinafter, it shall be unlawful for a child to attend any school, kindergarten, or facility intended for the instruction of children, either public or private (with the exception of any legitimate home instruction program as defined in Section 37 13 9), unless they have been vaccine against those diseases specified by the state health officer.

A certificate of exemption from vaccination for medical reasons may be offered on behalf of a child by a duly licensed physician and may be accepted by the local health officer if, in his/her opinion, such exemption will not cause undue risk to the community.

Certificates of vaccination shall be issued by local health officers or physicians on forms specified by the Mississippi State Board of health. These forms shall be the only acceptable means for showing compliance with these immunization requirements, and the responsible school officials shall file the form with the child's record.

If a child tries to enroll in school without the required vaccinations, the local health officer may grant the student up to ninety (90) days for such completion if it will not cause undue risk to the child, school, or community. No child shall be permanently enrolled without having had at least one (1) dose of each specified vaccine.

Within thirty (3) days after the opening of school (on or before October 1 of each year), the delegated person in each school shall report to the county or local health officer (on forms provided by the Mississippi State Board of Health) the number of children enrolled by age or grade (or both), the number fully vaccinated, the number in the process of completing the vaccinations, and the number exempt from vaccinations and for what reasons.

Within one hundred twenty (120) days after the opening of school (on or before December 31), the delegated person in each school shall certify to the local or county health officer that all children enrolled are in compliance with immunization requirements.

To assist in the supervision of the immunization status of the children, the local health officer (or designee), may inspect the children's records or be furnished certificates of immunization compliance by the school.

It shall be the responsibility of the person in charge of each school to enforce the requirements for immunization. Any child not in compliance at the end of ninety (90) days from the opening of the fall term must be suspended until they are in compliance, unless the health officer attributes the delay to lack of supply of vaccine or some other factor clearly making compliance impossible.

Failure to enforce provisions of this section shall constitute a misdemeanor and upon conviction be punishable by fine or imprisonment or bot. `41 23 37 (1983)

LEGAL REF.: MS CODE as cited

CROSS REF.: Policies JGB- Medical Exam for Athletes
JGC- Student Health Services
JGCC- Communicable Diseases

Section: J- Students
Policy Code: JGCDA- Asthma Medications Policy

ASTHMA MEDICATION POLICY

A student with asthma may possess and use asthma medications when at school, at a school-sponsored activity, or before and after normal school activities while on school properties (including school-sponsored child care or after-school programs) according to the guidelines set forth by the MDE and outlined in this policy. Emergency Epinephrine is also included in this policy if required for treatment of severe life-threatening allergies.

REQUIRED AUTHORIZATION

Students may self-administer asthma medication if their parent or guardian:

1. Provides written authorization or self-administration form to the school (page 19.)
2. Provides an asthma action plan from the student's health care practitioner that the student has asthma and has been instructed in self-administration of asthma medications. The statement shall also contain the following information:
    - The name and purpose of the medications
    - The prescribed dosage
    - The time (s) the medications are to be regularly administered and under what additional special circumstances, if any
    - The length of time for which the medications are prescribed.
    - The signature of the child's health care practitioner, along with the date

The documentation listed above shall be kept on file in the school's office or nurse's office.

INDEMNIFICATION AND LIABILITY

Parents/Guardians shall be informed that the school and its employees and agents shall incur no liability as a result of any injury sustained by the student from the self-administration of asthma medications. The parent/guardian shall sign a statement acknowledging the school shall incur no liability, and he/she shall indemnify and hold harmless the school and its employees against any claims relating to the self-administration of asthma medications.

YEARLY RENEWAL

The permission for self-administration of asthma medications shall be effective for the school year in which it is granted and must be renewed each following school year.

LEGAL REF.: House Bill 1072, 2003 Mississippi Legislative Session
CROSS REF.: Policy JGCD- Medicines

Exhibits:

ADDITIONAL POLICIES:

JGC- Student Health Services
JGFG   Accidents / First Aid
JGCD   Student Health Services -- Medicines

Section: J Students

Policy Code: JGC Student Health Services

Policy:

STUDENT HEALTH SERVICES

Although the district's primary responsibility is to educate students, the student's health and general welfare is also a major Board concern. The Board believes school programs should be conducted in a manner that protects and enhances student and employee health and is consistent with good health practices.

The district recognizes its responsibility to notify parents in advance of any non-emergency, invasive physical examination or screening that is required as condition of attendance; administered and scheduled by the school in advance; and not necessary to protect the immediate health and safety of the student, or of other students.

The term "invasive physical examination," as defined by law, means any medical examination that involves the exposure of private body parts, or any act during such examination that includes incision, insertion, or injection into the body, but does not include a hearing, vision or scoliosis screening. The term does not include any physical examination or screening that is permitted or required by state law, including physical examinations or screenings that are permitted without parental notification.

Procedures shall be developed and implemented to carry out this policy. All district employees will be apprised of their responsibilities in this area. Parents shall have the opportunity to request their students be exempt from participation in vision or hearing screening. The district will abide by those requests.

HEAD LICE

For any student who has had head lice on three (3) consecutive occasions during one (1) school year, the student should consult with their medical provider or certified lice clinic for treatment. It is not necessary to remove the infested child from the school before the end of the school day. The School Principal or Administrator shall not allow the child to attend school until proof of treatment is obtained 41-79-21.

BED BUGS

If a confirmed bed bug was found on a student, the Principal or School Nurse should contact the student's parent/guardian to inform them. The student should not be excluded from school unless repeated efforts have not been made by the parent to remedy the infestation.

GENERAL PROVISIONS

The district shall maintain a prevention oriented health services program which provides:

1. Pertinent health information on the students, as required by Mississippi statutes or rules;

2. Health appraisal to include screening for possible vision or hearing problems [and also scoliosis];

3. Health counseling for students and parents when appropriate;

4. Health care and first-aid assistance that are appropriately supervised and isolates the sick or injured child from the student body;

5. Control and prevention of communicable diseases as required by Mississippi Department of Human Services, Health Services and the county health department;

6. Assistance for students in taking prescription and/or nonprescription medication according to established district procedures;

7. Services for students who are medically fragile or have special health care needs;

8. Integration of school health services with school health education programs.

[The nurse(s) employed by the district shall be licensed to practice as a licensed practical nurse, registered nurse or nurse practitioner in Mississippi and will function as an integral member of the instructional staff, serving as a resource person to teachers in securing appropriate information and materials on health-related topics.]

The Board directs its district health staff to coordinate with health personnel from other public agencies in matters pertaining to health instruction or the general health of students and employees.

The local school board of each school district shall establish a local school health council for each school which shall ensure that local community values are reflected in the local school's wellness plan to address school health. Such councils shall be established no later than November 1, 2006. ' 37-13-134 (8) (2006)

The Mississippi Public School Accountability Standard for this policy is standard 6.

LEGAL REF.: MS CODE as cited; P. L. 107-110 (No Child Left Behind Act)
Mississippi Public School Accountability Standards
CROSS REF.: Policies ICI - Health / Physical Education Advisory Council
JGCC - Communicable Diseases
JGCD - Student Health Services -- Medicines

Last Review Date:__________________
Review History:[1/1/1900][1/1/1901]

Section: J Students

Policy Code: JGFG Accidents / First Aid

Policy:

ACCIDENTS / FIRST AID

Every accident in the school building, on school grounds, at practice sessions, or at any athletic event sponsored by the school must be reported immediately to the person in charge and to someone in the school office. All accident forms must also be completed and sent to the school nurse to be filed. All supervising staff must complete a memo-to-record account of the accident.

In the event that a child needs medical attention and a parent or other designated person cannot be reached, an ambulance will be called at the parent's expense.

PROGRAM OF FIRST AID

Each principal shall have a written program for handling emergencies resulting from accidents or sudden sicknesses of students. The program shall be approved by the superintendent. This first aid program shall provide direction for giving immediate care, notifying parents/guardians, getting the student home, and directing the parent, when necessary, to the source of treatment. The program of first aid shall incorporate the following requirements:

1. The principal or another trained person shall be responsible for administering first aid.
2. If the illness or injury appears to be serious, every effort shall be made to contact the parent and/or family physician immediately.
3. No student who is ill or injured shall be sent home alone. He /She shall not be taken home unless someone is there to receive him.
4. In extreme emergencies, the principal may make arrangements for hospitalization of injured or ill students, contacting the parent/guardian in advance if possible.
5. The teacher/staff member responsible for the student at the time of an accident shall make out a report providing details about the accident. Reports shall be maintained by the building level school nurse for proper disposition.
6. Serious accidents to students shall be reported as soon as possible to the superintendent.

FIRST AID SUPPLIES

Principals shall maintain an adequate supply of first aid supplies which shall be made available as are other school supplies.

ACCIDENT REPORTING

Each principal shall report all injuries to students/employees that require medical attention or keep the student/employee from school/work one-half day or more. The report shall be made on the district's accident report form.

MEDICATION

School personnel shall not exceed the standard practice of competent first aid. They shall not diagnose, and shall not administer medication unless they have been designated by their building principal to do so, and have been trained by the school nurse using the Board of Nursing's Assisted Self-Administration Curriculum.

FIRST AID TRAINING

Principals shall ensure that one-third of the instructional staff of the school is currently certified by the American Heart Association or the American Red Cross to administer first aid and perform CPR. All physical education teachers in the secondary schools shall be currently certified to give first aid.

All coaches in accordance with MHSAA should be certified in CPR and First Aid.

Staff members who have been trained in CPR and First Aid will be allowed to render care in accordance with their training and will be protected under the Good Samaritan Law in the State of Mississippi.

CROSS REF.: Policies JGCD - Medicines
JGD – Safety During Instruction

Last Review Date:__________________
Review History:[1/1/1900][1/1/1901]

MEDICINES PROCEDURES

The following medicine procedure will be adhered to in the Lowndes County School District:

1. Parents must provide all medications to be given at school. Lowndes County Schools does not provide any medication for students.
2. In order for a student to take **ANY** medication (**including all over the counter medications, such as Tylenol or Advil)** at school, the parent must obtain a medication authorization form from the school nurse or school office, or print it from the school website, and have it completed and signed by the doctor. The parent must also sign the form and bring the completed form along with the medication to the school nurse (page 20.)
3. **Parents should not send medication to school by the student.**
4. Prescription medication must be brought to school in the pharmacy labeled bottle, which contains instructions on how and when the medication is to be given. Over the counter medications must be in its original container.
5. The principal of each school will designate someone to administer all medication. The designee, if not the nurse, will be given instruction or training to insure he/she can safely administer the medications.
6. School personnel will follow the written direction of the student's medical provider in administering all medication.
7. Students are admonished and instructed not to bring any medication to school, including over the counter medications. Any student bringing medication to school and giving it to another student will be disciplined.
8. **For children known to have severe or life threatening allergies [or serious medical conditions (seizures, diabetes, asthma etc., which require emergency medications)] parents should:**

    a. Inform the school nurse and the child's teacher of their child's life-threatening condition at the beginning of the school year, or as soon as possible after the diagnosis. All severe allergies must be verified by documentation from a medical provider.

    b. Complete and submit all required medication forms.

    c. Provide the school with current cell phone, pager, etc. and maintain updated contact numbers and medical information.

    d. Provide the school nurse with up-to-date emergency medication (including epinephrine, diastat, and glucagon), so they can be placed in all required locations for the current school year.

    e. Provided epinephrine, diastat, glucagon or any other emergency medication on field trips.

    f. Accompany their child on field trips, if possible. If a student has emergency medication for seizures, diabetes, or any other medical conditions that require close supervision, a parent or adult chosen by the parent will be required to accompany the child.

    g. Inform the school of any changes in the child's life-threatening allergy status.

h. Provide the school with a statement from the medical provider if the student no longer has life threatening allergies or other medical conditions.

i. For food allergies that may cause a need for the diet to be changed from the regular meal pattern in the cafeteria, a **Mississippi Department of Education Office of Child Nutrition Medical Statement** (for Non-Disabled or Disabled Child) should be completed by the student's ~~Doctor~~ medical provider at the beginning of the school year or as soon as diagnosed. The parent can obtain a copy of this form from the school nurse, the school office, or the school website (Pages16- 18.)

All necessary permission slips, request forms, etc., must be signed before the above and foregoing policy is carried out in relation to administering any medication to the student.

The Lowndes County School district will administer first aid and emergency treatment to insure the safety of its students.

Return to School Guidelines for Ill Student and Staff

If a student presents with symptoms of illness, such as fever of 100.4 or greater, vomiting, or diarrhea, or other symptoms per the discretion of the school nurse, the student may need to be assessed by a medical provider. The student may return to school once they have been fever free for 24 hours without the use of fever reducing medications, has had no vomiting in the last 24 hours, or with a note from a medical provider stating they may return to school.

Appendix

Mississippi Department of Education
Office of Child Nutrition
Medical Statement for Disabled Child

Part I *(to be completed by School District/School/Organization/Sponsor)*

Date ___________________________

Name of School District/School/Organization/Sponsor __________________________________

Name of Student/Disabled Person ____

Address ____

____Date of Birth ________________

School/Provider/Center Name ____

School/Provider/Center Address ____

Part II *(to be completed by the Medical Provider)*

Patient's Name ____ Age _______

Diagnosis ____

____

Does the disability restrict the individual's diet? Yes _____ No ______

If yes, list food(s) to be omitted from diet and food(s) that may be substituted _______________

____

Special equipment needed____

____

____

____________________ ___________________________________

Date Signature of Medical Provider

Mississippi Department of Education
Office of Child Nutrition
Medical Statement for Non- Disabled Child

Part I *(to be completed by School District/School/Organization/Sponsor)*

Date ___________________________

Name of School District/School/Organization/Sponsor __________________________________

Name of Student/Individual ____

Address ____

____Date of Birth ________________

School/Provider/Center Name ____

School/Provider/Center Address ____

Part II *(to be completed by the Medical Provider)*

Patient's Name ____ Age _______

Diagnosis ____

____

Describe the medical or other special dietary needs that restrict the child's diet________________

____

____

If yes, list food(s) to be omitted from diet and food(s) that may be substituted ________________

____

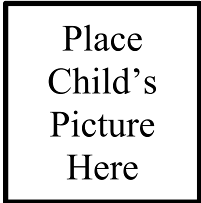
____

Special equipment needed____

_____________________ ____________________________________

Date Signature of Medical Provider

Food Allergy Action Plan



Student's Name: ____________________________ D.O.B. __________Teacher: ________________

ALLERGY TO: ____

Asthmatic Yes* ☐ No ☐ *Higher risk for severe reaction

◆Step 1: Treatment ◆

Symptoms:	**Give checked Medication**** **(To be determine by physician authorizing treatment)
If a food allergen has been ingested, but no symptoms:	☐ Epinephrine ☐ Antihistamine
Mouth Itching, tingling, or swelling of lips, tongue, mouth	☐ Epinephrine ☐ Antihistamine
Skin Hives, itchy rash, swelling of the face or extremities	☐ Epinephrine ☐ Antihistamine
Gut Nausea, abdominal cramps, vomiting, diarrhea	☐ Epinephrine ☐ Antihistamine
Throat Tightening of throat, hoarseness, hacking cough	☐ Epinephrine ☐ Antihistamine
Lung¤ Shortness of breath, repetitive coughing, wheezing	☐ Epinephrine ☐ Antihistamine
Heart¤ Weak or thread pulse, low blood pressure, fainting, pale, blueness	☐ Epinephrine ☐ Antihistamine
Other	☐ Epinephrine ☐ Antihistamine
If reaction is progressing (several of the above area affected) give:	☐ Epinephrine ☐ Antihistamine

¤Srwhqwldo|#dih0wkuhdwhqlqj#wkh#vhyhulw|#ri#v|pswrpv#fdq#txlfno|#fkdqjh,#

Dosage
Epinephrine: Inject intramuscularly(circle one) Epi Pen® Epi Pen® Jr. Twinject® 0.3 mg Twinject® 0.15 mg(see reverse side for instruction)

Antihistamine: give ____
Medication/dose/route

Other: give ____
Medication/dose/route

Important: Asthma inhaler and/or antihistamine cannot be depended on to replace epinephrine in anaphylaxis.

◆ STEP 2: EMERGENCY CALLS ◆

1. Call 911 (or Rescue Squad: ___________) State that an allergic reaction has been treated, and additional epinephrine may be needed.

2 Medical Provider: ____ Phone Number: ____________________________

3. Parent: ____ Phone Number(s) ____________________________

4. Emergency contacts:

Name/ Relationship | Phone Number(s)

A ______________________________ 1) ________________________ 2) __________________________

B_______________________________ 1) ________________________ 2) __________________________

EVEN IF A PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY

Parent/Guardian's signature _______________________________________ Date_____________________________

Medical Provider's Signature____ Date__________________
____

(required)

LOWNDES COUNTY SCHOOL DISTRICT

Medication Authorization for Self-Administration

Student Name:	Date of Birth:
School:	Grade:
Mother's Name:	Home Phone: Work/Cell:
Father's Name:	Home Phone: Work/Cell:
Medical Provider's Name:	Telephone:

_______This student may carry and self-administer the following medications at school.
_______This student may carry the following medication for administration BY school personnel.

Name of medication:______________________________

Dosage: ____________________Time:_______________

Start Date: _______________End Date: _______________

Symptoms that may indicate need for medication:
____
____

Factors that may trigger/precipitate symptoms:
____
____

Specific instructions if student has symptoms:
____
____

MEDICAL PROVIDER'S APPROVAL

I agree with the above medication plan, including the name, purpose, dosage and administration directions of the medication.

It is my professional opinion that this student should be permitted to carry and self-administer this medication.

____
Medical Provider's Signature Date

PARENTAL CONSENT & RESPONSIBILITIES

I, the parent/guardian of the above named child, understand and agree to the conditions of the school policy on medication administration. I permit the school to seek emergency medical treatment for my child when deemed necessary and appropriate. I give authorization for self– administration and possession of the named medication by my child while at school, at school-sponsored activities, while under the supervision of school personnel and while in before-or after-school care on the school property. My child demonstrates a full understanding of the proper use of this medication.

I am responsible for: (1) Monitoring the medication, medication use, and supplying the medication. (2) Ensuring my child always carries this medication on his/her person. (3) Deciding if back-up medication will be kept at school, and providing the school with back-up medication. (4) Informing the school in writing of any changes in treatment or medical condition of my child. (5) Informing the school of any medication side effects of which I should be notified.

I consent for the Medical Provider to release information about my child related to this medication to the school nurse.

I release Lowndes County School District its employees of any legal responsibility related to my child's possession and self-administration of this medication.

____
Parent/Guardian Signature Date

STUDENT AGREEMENT: I understand and agree to follow the Lowndes County School District's policy for self-administration of my medication while ate school. I have been instructed in the proper use of this medication. I will be responsible for carrying the medication and will not allow another student to use my medication under any circumstances.

Student Signature____ Date________________

Lowndes County School District
Medication Authorization Form

Medication will be administered in school ONLY when it is necessary for a student to remain in school. Medication should be brought to school by the parent/guardian for a student ONLY WHEN IT IS AN ABSOLUTE NECESSITY.

The purpose of this policy is to ensure that students receive necessary medication according to their physician's orders and to insure maximum safety for all concerned. Please understand that your signature on this form authorizes other school personnel to supervise your child with medication administration when the school nurse is not available.

Should you be asked to complete one of these forms, please read the form thoroughly and respond to ALL items. Contact the school nurse if you have any questions. THANK YOU.

One form must be completed and signed by parent AND physician ANNUALLY for EACH medication. All medications must be picked up by the parent/guardian at the end of the school year or they will be disposed of.
****

MEDICAL PROVIDER'S STATEMENT:

Date:___________________

Student's Name:______________________________________ Date of Birth:___________________

Diagnosis:____

Name of Medication:_______________________________ Dosage:___________________________

Time of Administration:___________________________ Termination Date:_____________________

Side Effects/Special Instructions for Medication:____
____

Medical Provider's Signature:________________________________ Phone:__________________________

Medical Provider's Name (Print):____
****

PARENT/GUARDIAN STATEMENT:

I hereby request that this medication be given to my child according to the physician's instruction. I agree to furnish the necessary medication in a pharmacy/original labeled container, to provide replacement medication as necessary, and to provide a new physician's statement if there is ANY change in the medication, dosage, administration time, administration route or special instructions regarding the medication. I understand that other designated personnel (other than school nurse) may give my child's medication or supervise the child with self-administration of the medication. I waive any liability claim against school staff assisting my child in taking medication.

Parent's/Guardian's Signature:____ Date:______________

Asthma Action Plan

General Information:

- Name ______________________
- Emergency contact ______________________ Phone numbers ______________
- Physician/healthcare provider ______________________ Phone numbers ______________
- Physician signature ______________________ Date ______________

Severity Classification	Triggers	Exercise
❍ Intermittent ❍ Moderate Persistent ❍ Mild Persistent ❍ Severe Persistent	❍ Colds ❍ Smoke ❍ Weather ❍ Exercise ❍ Dust ❍ Air Pollution ❍ Animals ❍ Food ❍ Other __________	1. Premedication (how much and when) ______ ______________ 2. Exercise modifications ______________ ______________

Green Zone: Doing Well

Peak Flow Meter Personal Best =

Symptoms

- Breathing is good
- No cough or wheeze
- Can work and play
- Sleeps well at night

Peak Flow Meter

More than 80% of personal best or __________

Control Medications:

Medicine	How Much to Take	When to Take It

❍ Change your long-term control medicine by ______________

❍ Contact your physician for follow-up care.

❍ Call your physician/Healthcare provider within ____ hour(s) of modifying your medication routine.

Red Zone: Medical Alert

Ambulance/Emergency Phone Number:

Symptoms

- Lots of problems breathing
- Cannot work or play
- Getting worse instead of better
- Medicine is not helping

Peak Flow Meter

Less than 50% of personal best or

__________ to __________

Continue control medicines and add:

Medicine	How Much to Take	When to Take It

Go to the hospital or call for an ambulance if:

❍ Still in the red zone after 15 minutes.

❍ You have not been able to reach your physician/healthcare provider for help.

❍ ______________

Call an ambulance immediately if the following danger signs are present:

❍ Trouble walking/talking due to shortness of breath.

❍ Lips or fingernails are blue.

Rev_July_2008

ACCIDENT/INCIDENT REPORT

School: ________________________Date (of occurrence):______/ ______ /______; Time: ___________a.m. / p.m.

Name: __________________________________ Gender: ☐ Male ☐ Female ☐ D.O.B.:______________

Street Address:_________________________________City/State:____________________Zip:________Phone: ___________

Grade/Teacher (if student): _________________________Title (if employee):_____________________________________

Parent or guardian notified (if student): ____

Family or friend notified (if employee): ____

Street Address:_________________________________City /State:____________Zip:__________Phone: _________________

Location of accident/incident: ☐ Classroom ☐ Bus ☐ Gym ☐ Cafeteria ☐ Playground
☐ Steps ☐ Sidewalk ☐ Other: ____

Cause of accident: ☐ Collision with person ☐Collision with obstacle (specify):___________________________________
☐ Hit with projectile (specify):___________ ☐Sudden turn, twist, or stop
☐ Fall (specify surface):________________ ☐Fighting
☐ Other:
____

Description of how occurred: ____
Witness(is):______________________________________Teacher(s) on duty: _______________________________________

Body part(s) injured (note which side where applicable):

___Abdomen:	☐Left	☐Right	__ Ankle	☐Left	☐Right	__Clavicle	☐Left	☐Right
___Arm (upper):	☐Left	☐Right	__ Foot	☐Left	☐Right	__Shoulder	☐Left	☐Right
___Arm (lower):	☐Left	☐Right	__ Knee	☐Left	☐Right	__Trunk	☐Left	☐Right
___Elbow:	☐Left	☐Right	__ Leg:	☐Left	☐Right	__Back:	☐Left	☐Right
___Finger:	☐Left	☐Right	__Toe(s):	☐Left	☐Right	__Eye(s):	☐Left	☐Right
___Hand:	☐Left	☐Right	__ Hip(s):	☐Left	☐Right	__Ear(s):	☐Left	☐Right
___Wrist:	☐Left	☐Right	__ Groin:	☐Left	☐Right	__Head	☐Left	☐Right

___Other (specify) ____

Type of injury suspected (please check):
__Bruise __Concussion ___Dislocation ___Fracture ___Laceration
__Sprain, Strain __Other (specify):_________________________________

First aid or assistance provided (please check):

____Cleansed wound with soap and water ____ Cleansed wound with saline

____Applied ice ___ Applied compress ____ Controlled bleeding ____ Applied splint

____Applied sling ___ Applied bandage, dressing ____ Immobilized ____ Other: _________________

Further care:
____Parent or relative took home ___Parent or relative took to doctor

____Ambulance transport ___Parent or relative took to emergency room

____ Other (specify): ____

Absence due to accident/incident: ____
Comments: ____

Name of person reporting:____________________________Title:_________________Date: ________________
Nature of principal or administrator: ____________________________________Date:_____________________
Follow-Up Remarks____
____ **Int./Date** _____________

Parent Emergency Information form

Student's Name________________________________Grade____________Homeroom______________________

D.O.B_________________Weight _____________Home#__________________Emergency#__________________

Student's Doctor_______________________________Dr's #_______________________Medicaid Yes____No_____

Allergies: Yes__ No___ Foods: (list)____(Foods that must be omitted

in cafeteria **required nutrition form from Dr.)** Other: (List) ____

Is Epi Pen required? Yes __ No___ (**Med. Form & allergy plan required from Medical Provider**)

Medications: Taken at home: (List)_____________ School:(List) _____________(**Med. Form required from Medical Provider**)

Please circle below if your child has any of the following illness:

1. HEART DISEASE	4. BLIND	7. ASTHMA	10. SEIZURES
2. DIABETES	5. DEAF	8.PHYSICAL HANDICAP	11. HEARING AIDS
3. HYPOGLYCEMIA	6. CANCER	9. HEMOPHILIA	12. Glasses: Full time: Yes__ No__

13. Is inhaler requires at school for asthma? Yes ____ No____ **(Med. Form & asthma plan required)**

14. Does your child have seizures? Yes___ No___ What kind? ___________________ Date last seizure? _______

Is emergency medicine required at school? Yes ____ No____ **(Med. Form & asthma plan required)**

15. Any other health problems? Yes ____ No _____ Explain: ____

16. Any special nursing care required during school nurse hours? Yes___No___ Explain: _____________________

17. Any restriction on physical activity? Yes___ No ____ Explain_________________________

I understand the LCSD medication policy stating that I am responsible for all medical paperwork (medication orders and action plans), supplies, and medications to be given during school hours regarding my child's medical diagnosis. I also waive any liability claim against Lowndes County Schools in case of accident/illness while transporting my child for medical attention.

__________________ ______________________________

Date Signature of parent or guardian