

**LOWNDES COUNTY**  
*School District*  
CALEDONIA • NEW HOPE • WEST LOWNDES • CAREER TECH

# **Student Health Services Handbook 2018-2019**

**Board of Education Approved:  
12/8/17 (Content 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:

Robert Barksdale  
Jacqueline Gray

Brian Clark, President  
Wes Barrett, Vice President

Jane Kilgore, Secretary  
Jeff Smith, Attorney

**CENTRAL OFFICE ADMINISTRATION**

Lynn Wright, Superintendent ----- 244-5005  
Dr. Robin Ballard, Deputy Superintendent----- 244-5019  
Dr. Susan Johnson, Assistant Superintendent ----- 244-5027  
Kenneth Hughes, Business Office Administrator ----- 244-5016  
Percy Lee, Vocational & Tech Prep Director ----- 2445008  
Jeanise Andrews, Technology Coordinator ----- 244-5018  
Susan Lingle - McClelland, Curriculum Coordinator----- 244-5007  
Veronica Hill, Human Resources----- 244-5010  
Kristie Jones, Title I Supervisor ----- 244-5030

**SUPPORT STAFF**

Susan Byars, Director of Child Nutrition----- 244-5021  
Greg Wheat, Maintenance Supervisor ----- 434-6123  
James Patrick, Transportation Supervisor ----- 434-6299  
Roger Gaudet, Network Manager ----- 244-5006  
Jennifer Maness, Positive Behavior Specialist -----356-2001  
Spence Andrews, Assessment Coordinator ----- 244-5049

**LOWNDES COUNTY SCHOOL DISTRICT SCHOOLS**

Caledonia Elementary School (K-5) -----Roger Hill, Principal  
99 Confederate Drive, Caledonia, MS 39740----- Phone 356-2050-Fax 356-2065

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

Caledonia High School (9-12) ----- Dr. Andy Stevens, Principal  
111 Confederate Drive, Caledonia, MS 39740 ----- Phone 356-2001- Fax 356-2036

New Hope Elementary School (K-5)-----Dr. Christy Adams, Principal  
199 Enlow Drive, Columbus, MS 39702----- Phone 244-4760-Fax 244-4775

New Hope Middle School (6-8) ----- Sam Allison, 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) ----- Stefanie Jones, Principal  
644 South Frontage Road, Columbus, MS 39701 ----- Phone 244-5070 - Fax 327-3353

Alternative School -----Antonio Magee, Principal  
3419 New Hope Road, Columbus, MS 39702----- . Phone 244-5060-Fax 327-4857

Career & Technical Center-----Percy Lee, Director  
1085 Lehmborg 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

## **Caledonia Campus**

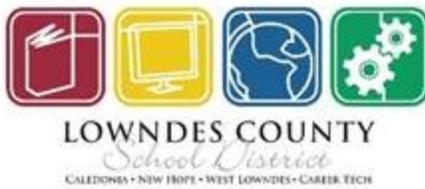
Casey Clark (662) 356-2056  
Katie Elliott (662) 356-2048

## **West Lowndes Elementary**

Rachael Young (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.

Except 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 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

District: Lowndes County School District  
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 a written statement 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.

Notification will be provided at least annually at the beginning of the school year or when enrolling students for the first time in school and will include the specific or approximate dates during the school year when such activities are scheduled or expected to be scheduled.

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 [scoliosis,] 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 principal shall notify the county health department of the recurring problem of head lice with that student. The student shall not be allowed to attend school until proof of treatment is obtained. '41-79-21

### **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 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 they shall not administer medication of any kind.

## FIRST AID TRAINING

Principals shall ensure that one-third of the instructional staff of the school is currently certified by 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]

**Section:** J Students

**Policy Code:** JGCD Student Health Services -- Medicines

**Policy:**

## **MEDICINES**

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

1. No oral over-the-counter medication drugs will be kept by this school district.
2. Parents must bring to the schools any prescription drugs to be administered.
3. Students are admonished and instructed not to bring any over-the-counter medication to school except for those under prescription from a medical provider in accordance with this policy. Any student bringing over-the-counter medication to school and giving it to another student will be disciplined.
4. The principal of each school will designate someone to administer prescription drugs. The designee, if not the nurse, will be given some instruction or training to insure he/she can safely administer the medications requested by the parents of the student.
5. School personnel will not administer any prescription medication to students until they have received a medication form completed and signed by the doctor, along with the medication in an appropriately labeled container.
6. Over-the-counter medication will only be administered on a daily basis for temporary conditions. The parent must bring to the school a new, written note of instructions, along with the over-the-counter medications, each day they are required. These over-the-counter medications will not be kept at school for any student.
7. School personnel must follow the reasonable, written request of the parent/guardian in administering non-prescription drugs and the written direction of the student's physician in administering prescription drugs.

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.

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

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 do 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 physician 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 Physician or Nurse Practitioner.
  - 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. Go on field trips with their children 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, or the child will not be able to attend the field trip.
  - g. Inform the school of any changes in the child's life threatening allergy status.

- h. Provide the school with physician's statement 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 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 (Pages 16- 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.

# **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 Physician)*

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 Physician

**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 Medical Authority)*

Patient's Name \_\_\_\_\_ Age \_\_\_\_\_

Diagnosis \_\_\_\_\_

Describe the medical or other special dietary needs that restrict the child's diet \_\_\_\_\_

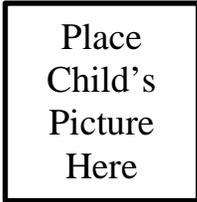
If yes, list food(s) to be omitted from diet and food(s) that may be substituted \_\_\_\_\_

Special equipment needed \_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Medical Authority

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

†Potentially life-threatening (the severity of symptoms can quickly change)

### **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. Dr. \_\_\_\_\_ 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 \_\_\_\_\_

Doctor'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: <span style="float: right;">Work/Cell:</span>
Father's Name:	Home Phone: <span style="float: right;">Work/Cell:</span>
Physician'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.

<p>Name of medication: _____</p> <p>Dosage: _____ Time: _____</p> <p>Start Date: _____ End Date: _____</p> <p>Symptoms that may indicate need for medication:          _____          _____</p> <p>Factors that may trigger/precipitate symptoms:          _____          _____</p> <p>Specific instructions if student has symptoms:          _____          _____</p> <p><b>PHYSICIAN APPROVAL</b></p> <p>I agree with the above medication plan, including the name, purpose, dosage and administration directions of the medication.</p> <p>It is my professional opinion that this student should be permitted to carry and self-administer this medication.</p> <p>_____          Physicians Signature <span style="float: right;">Date</span></p>	<p style="text-align: center;"><b>PARENTAL CONSENT &amp; RESPONSIBILITIES</b></p> <p>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.</p> <p>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.</p> <p>I consent for the physician to release information about my child related to this medication to the school nurse.</p> <p>I release Lowndes County School District its employees of any legal responsibility related to my child's possession and self-administration of this medication.</p> <p>_____          Parent/Guardian Signature <span style="float: right;">Date</span></p>
--	--

**STUDENT AGREEMENT:** I understand and agree to follow the Lowndes County School District's policy for self-administration of my medication while at 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 the 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 ensure 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 ANNUALLY for EACH medication PRESCRIPTION.*

**PHYSICIAN'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: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician's Name (Print): \_\_\_\_\_

\*\*\*\*\*

**PARENT AUTHORIZATION AND INDEMNITY AGREEMENT**

The undersigned parent/s or guardian/s of \_\_\_\_\_, a minor child, has requested personnel of this school district to administer prescription medicine to this student. This request has been made for my/our convenience as a substitute for parental administration of this medicine. It is understood that school personnel administering the medicine will not have to have medical or nursing training.

I /We forever release, discharge and covenant to hold harmless the School District, its personnel and Board of Trustees from any all claims, demands, damages, expenses, loss of services and causes of action belonging to the minor child or to the undersigned arising out of or on account of any injury, sickness, disability, loss or damages of any kind resulting from the administration of the prescription medicine.

The undersigned agree to repay the school district, its personnel or Trustees any sum of money, expenses, or attorney's fees that any of them may be compelled to pay in defense of any action or on account of any such injury to the minor child as a result of the administration of medicine.

I have read the foregoing release and indemnity agreement and fully understand it.

Executed this the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
Parent or Guardian

\_\_\_\_\_  
Witness

# Asthma Action Plan



## General Information:

Name \_\_\_\_\_  
 Emergency contact \_\_\_\_\_ Phone numbers \_\_\_\_\_  
 Physician/healthcare provider \_\_\_\_\_ Phone numbers \_\_\_\_\_  
 Physician signature \_\_\_\_\_ Date \_\_\_\_\_

Severity Classification	Triggers	Exercise
<input type="radio"/> Intermittent <input type="radio"/> Moderate Persistent <input type="radio"/> Mild Persistent <input type="radio"/> Severe Persistent	<input type="radio"/> Colds <input type="radio"/> Smoke <input type="radio"/> Weather <input type="radio"/> Exercise <input type="radio"/> Dust <input type="radio"/> Air Pollution <input type="radio"/> Animals <input type="radio"/> Food <input type="radio"/> 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

## Yellow Zone: Getting Worse

## Contact physician if using quick relief more than 2 times per week.

### Symptoms

- Some problems breathing
- Cough, wheeze, or chest tight
- Problems working or playing
- Wake at night

### Peak Flow Meter

Between 50% and 80% of personal best or \_\_\_\_\_ to \_\_\_\_\_

### Continue control medicines and add:

Medicine	How Much to Take	When to Take It

**IF your symptoms (and peak flow, if used) return to Green Zone after one hour of the quick-relief treatment, THEN**

- Take quick-relief medication every 4 hours for 1 to 2 days.
- Change your long-term control medicine by \_\_\_\_\_
- Contact your physician for follow-up care.

**IF your symptoms (and peak flow, if used) DO NOT return to Green Zone after one hour of the quick-relief treatment, THEN**

- Take quick-relief treatment again.
- Change your long-term control medicine by \_\_\_\_\_
- 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.

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 \_\_\_\_\_ Home Phone \_\_\_\_\_ Emergency Phone \_\_\_\_\_

Student's Doctor \_\_\_\_\_ Phone # \_\_\_\_\_ Medicaid Yes \_\_\_ No \_\_\_

ALLERGIES \_\_\_\_\_ Is Epi Pen required? Yes \_\_\_ No \_\_\_

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. Any other health problem  
\_\_\_\_\_
- 3. HYPOGLYCEMIA    6. CANCER            9. HEMOPHILIA

12. Does your child wear glasses? Full time \_\_\_\_\_ Reading only \_\_\_\_\_

13. Does student receive Chemotherapy? Yes \_\_\_ No \_\_\_\_\_

14. Any special nursing care or observation required during school nurse hours? Yes \_\_\_ No \_\_\_

15. Any restriction on physical activity? Yes \_\_\_ No \_\_\_ Explain \_\_\_\_\_

16. Medication student receives \_\_\_\_\_

17. Is inhaler required at school for asthma Yes \_\_\_ No

18. I give permission of the following:

- 1. Participate in school health programs. Yes \_\_\_ No \_\_\_
- 2. Receive first aid if needed. Yes \_\_\_\_\_ No \_\_\_\_\_
- 3. Receive treatment for minor skin disorders. Yes \_\_\_ No \_\_\_ (antifungal, calamine/cabalist)
- 4. Receive EMERGENCY CARE. Yes \_\_\_\_\_ No
- 5. Receive treatment for insect bites. Yes \_\_\_\_\_ No \_\_\_ (sting Kill)
- 6. To transport to local Hospital in case of emergency. Yes \_\_\_ No \_\_\_\_\_

I always wave any liability claim against Lowndes County Schools in case of accident while transporting my child for medical attention.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of parent or guardian