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| **Mercedes Independent School District**  **Office of Safe Schools/Student Services** |
|  |
| **Campus Medical Forms**  **\*For School Nurse Use Only\*** |
| Veronica Bustamante, RN District Head Nurse  206 W 6th  St., TX 78570  956-825-5075 |
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**MERCEDES INDEPENDENT SCHOOL DISTRICT**

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**CAMPUS MEDICAL FORMS**

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**Mercedes Independent School District**

***For school nurse use only:***

**Health Condition:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Vaccines up to date:**

Yes \_\_\_\_\_\_ No\_\_\_\_\_\_\_

**New to the District:** \_\_\_\_\_\_\_\_\_\_\_\_\_

**School transferred from:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**504\_\_\_\_\_ SPED**\_\_\_\_\_\_\_\_\_\_\_\_

**School Health History Form**

**Dear Parent:**

We would like your child to gain the most from his/her school experience. In order for us to assist in accomplishing this, it is necessary to have a current health history. Please complete this form and return it to your child’s school when you register.

Child’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Parent/guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Parent/guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\***Any parent that is not allowed to have access/contact with the child should not be added and appropriate documentation is required.**

Child’s Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**In case of an Emergency the school nurse/ campus personnel are unable to reach you, you authorize them to call:**

***(Two phone numbers are required)***

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health History:**

***Please ✓ the following if applicable to your child:***

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Health Problem** | **Yes** | **Treatment** | **Health Problem** | **Yes** | **Treatment** |
| Acanthosis |  |  | Epilepsy/Seizures Disorders |  |  |
| ADHD/ADD |  |  | Heart disorder |  |  |
| Anemia |  |  | Heart Murmur |  |  |
| Anxiety/Depression |  |  | Urinary/Kidney Problems |  |  |
| Asthma |  |  | Intellectual Disability/ MR |  |  |
| Autism |  |  | Bone/Muscle Disorder |  |  |
| Bleeding disorders |  |  | Neurologic Disorder |  |  |
| Bone Disorders |  |  | Obesity |  |  |
| Cancer, tumors |  |  | Oppositional defiant Disorder |  |  |
| Cerebral Palsy |  |  | Sickle Cell Disease |  |  |
| Cystic Fibrosis |  |  | Spina Bifida |  |  |
| Diabetes Type 1 |  |  | Speech/ Language problems |  |  |
| Diabetes Type 2 |  |  | Other |  |  |

***\*An asthma action plan is required for students using an inhaler during school. A seizure action plan is required for students with a seizure disorder. Excludes febrile seizures. If child needs to take medication in school, medication should be accompanied with a written consent by the parent/legal guardian. No over the counter medication or medication from Mexico will be given. See MISD Medication policy for more information.***

***\*\*\*\*More on Reverse side\*\*\****

***Page 1 of 2***

**Past hospitalizations or operations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ None: \_\_\_\_\_\_\_\_\_\_**

***Please ✓ the following if applicable to your child:***

**Severe Allergies/Anaphylaxis None**\_\_\_\_\_\_\_\_\_\_\_\_

Bee Sting: \_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Life Threatening? Yes or No Treatment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Peanut/Nut: \_\_\_\_\_\_\_\_\_\_\_\_ Reaction\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Life Threatening? Yes or No Treatment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Food: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Life Threatening? Yes or No Treatment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication: \_\_\_\_\_\_\_\_\_\_\_\_ Reaction \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Life Threatening? Yes or No Treatment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Life Threatening? Yes or No Treatment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***\* If your child has a severe allergy that requires an EpiPen in school, an Anaphylaxis plan will be needed and signed by your child’s doctor including a written consent from the parent/legal guardian to administer the medication on the plan. Ask the school nurse for the proper form.***

***Unassigned epinephrine auto-injectors will be available to any child if they do not have one prescribed for him/herself and experiencing an anaphylactic reaction. For more information: ask the school nurse or review student handbook.***

**Special Diet:**

Does your child require a special diet in school? Yes\_\_\_\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_\_ Diet\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\* *All special diets should be ordered by your child’s physician on the MISD diet form. Ask the school nurse for the proper form. Regular doctor’s order will not be accepted by the MISD nutrition department. If your child had a special diet last year, the diet will roll over for the new school yr.*

**Vision History:**

Child wears glasses: Yes\_\_\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_\_

Child is blind or visually impaired: Yes\_\_\_\_\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_

Lazy eye: Yes\_\_\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_

Failed a vision exam in school: Yes\_\_\_\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last vision exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ophthalmologist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Hearing History:**

Child has a hearing problem/impairment: Yes\_\_\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_

Has tubes placed in ears: Yes\_\_\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_\_

Frequent ear infections/earaches: Yes\_\_\_\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_\_\_

Failed a hearing exam in school: Yes\_\_\_\_\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_\_\_

Under care of a hearing specialist: Yes\_\_\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_\_\_ Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Uses a hearing device: Yes\_\_\_\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_\_\_ Device: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance:**

**How is care provided for this student? *Please ✓ the following if applicable:***

Private Insurance\_\_\_\_\_\_\_\_ Medicaid \_\_\_\_\_\_\_\_\_ CHIP \_\_\_\_\_\_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_No insurance\_\_\_\_\_\_\_\_\_\_\_\_

Last physical \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last dental check up\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**School Services**:

**Does your child receive any of the following services at school? *Please ✓ the following if applicable:***

504 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Special Education Program: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Speech Therapy\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dyslexia\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**This information will be kept confidential unless an emergency arises, or the nurse determines that the school team, transportation staff, or primary care provider have a need to know because of a specific health concern regarding your child. I give consent to share this information with school personnel and primary care provider if an emergency occurs or the nurse determines that there is a need to know to ensure the health, safety, and well-being of my child. I understand that it’s my (parent/guardian) responsibility to inform teacher(s) and school staff of my child’s health conditions. Nurse may contact physician to clarify medical diagnosis or medication dosage.**

***\*In case of an emergency and I cannot be reached, I, the undersigned do hereby authorize officials of the MISD to take the action necessary for the health of my child. MISD is not financially responsible for the emergency care and/or transportation of my child.***

**Parent/Guardian’s Signature Date**

***Page 2 of 2***

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***For school nurse use only:***

**Health Condition:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Vaccines up to date:**

Yes \_\_\_\_\_\_ No\_\_\_\_\_\_\_

**New to the District:** \_\_\_\_\_\_\_\_\_\_\_\_\_

**School transferred from:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**504\_\_\_\_\_ SPED**\_\_\_\_\_\_\_\_\_\_\_\_

**Distrito Escolar Independiente Mercedes**

**Formulario del Historial Médico Escolar**

**Estimado Padre de Familia:**

Deseamos que su hijo(a) alcance lo más que se pueda de su experiencia escolar. Con el fin de poder ayudarle a lograr esto, es necesario obtener su historial médico actual. Por favor llene este formulario y regréselo a la escuela de su hijo(a) cuando lo(a) inscriba.

Nombre del Alumno(a)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fecha de Nacimiento: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Domicilio\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grado\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Padre de Familia/Guardián\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Número Telefónico \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Padre de Familia/Guardián\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Número Telefónico \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\***Favor de omitir, en este formulario, el nombre del padre al que no se le permite acceso a su hijo(a). Favor de proporcionar prueba de esta documentación necesaria.**

Médico del Niño(a)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Número Telefónico\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**En caso de que la enfermera o el personal de la escuela no pueda comunicarse con usted en caso de una emergencia, usted da la autorización de llamar a:**

***(2 números telefónicos son requeridos)***

Nombre \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Relación) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Teléfono\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nombre \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Relación) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Teléfono\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Historial Médico:**

***Favor de poner una ✓ en el cuadro que sea aplicable a su hijo(a):***

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Problemas de Salud** | **Sí** | **Tratamiento** | **Problemas de Salud** | **Sí** | **Tratamiento** |
| Acantosis |  |  | Epilepsia/Ataques Epilépticos |  |  |
| ADHD/ADD |  |  | Trastornos Cardíacos |  |  |
| Anemia |  |  | Murmullo Cardíaco |  |  |
| Ansiedad/Depresión |  |  | Prolemas Urinarios/Riñón |  |  |
| Asma |  |  | Discapacidad Intelectual/ MR |  |  |
| Autismo |  |  | Trastorno Oseo/Muscular |  |  |
| Trastornos Sanguíneos |  |  | Trastornos Neurológicos |  |  |
| Problemas Oseos |  |  | Obesidad |  |  |
| Cáncer, tumores |  |  | Trastornos de Desafío Oposicional |  |  |
| Parálisis cerebral |  |  | Enfermeda de Sickle |  |  |
| Fibrosis Quística |  |  | Espina Bífida |  |  |
| Diabetes Tipo 1 |  |  | Trastornos de Habla / Lenguaje |  |  |
| Diabetes Tipo 2 |  |  | Otros |  |  |

***\*Se require un plan de acción para el asma para los estudiantes que usen inhaladores durante la escuela. Se require un plan de acción para los estudiantes que sufran de ataques epilépticos (se exluyen los ataques febriles). Si un niño(a) necesita tomar un medicamento durante la jornada escolar, entonces, el medicamento debe venir acompañado de un consentimiento del padre de familia/guardián legal por escrito. No se administrarán medicamentos libres ni medicamentos provenientes de México a los alumnos(as). Favor de ver la Regla de Medicamentos del MISD para mayores informes.***

***\*\*\*\*Ver parte de atrás de la hoja\*\*\****

***Page 1 of 2***

**Hospitalizaciones u Operaciones: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ninguno:** \_\_\_\_\_\_\_\_

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| ***Alergias Severas/ Anafilaxis*** |  | ***Ninguna:*** | |  | |
| **Producidaspor:** | **Amenaza la vida/Reacción:** | **Tratamiento:** | | | |
| Picadura de Abeja |  |  | | | |
| Cacahuates/Maní/Nueces |  |  | | | |
| Comida |  |  | | | |
| Medicamento |  |  | | | |
| Otras: |  |  | | | |
| ***\*Si a su hijo(a) le sucede una reacción severa que requiera Epi-Pen, se necesitará un plan de Anafilaxis firmado por el médico de su hijo(a), inclusive la aprobación por escrito del padre de familia o el guardián legal para administrar el medicamento. Favor de pedirle a la enfermera escolar el formulario apropiado.***  **Los autoinyectores de epinefrina no asignados estarán disponibles para cualquier niño si no tiene uno prescrito para sí mismo y experimenta una reacción anafiláctica. Para obtener más información: pregunte a la enfermera de la escuela o revise el manual del estudiante.** | | | | | |
|  | | |  | |  |
| **Dieta Especial:** | | | **Sí** | | **No** |
| ¿Requiere su hijo(a) una dieta especial para la escuela? | | |  | |  |
| ¿Cuáles la dieta?  \* Todas las dietas especiales deben traer una orden por parte del médico de su hijo(a) escrita en el formulario de dieta del MISD. Favor de pedirle a la enfermera el formulario correcto. El Departamento de Nutrición no aceptarán las órdenes médicas que no sean recibidas en el formulario correcto*.* Si su hijo/a contaba con una dieta especial el año pasado, la dieta continuara el siguiente año escolar. | | |  | |  |
| **Historial de la Visión:** | | | **Sí** | | **No** |
| ¿Su hijo(a) usa lentes? | | |  | |  |
| ¿Es ciego o tiene la visión perjudicada su hijo(a)? | | |  | |  |
| ¿Tiene ambliopía o sufre de ojo vago su hijo(a)? | | |  | |  |
| ¿Falló el examen de la vista en la escuela? | | |  | |  |
| ¿Cuándo se le examinó la vista la última vez? | | | | | |
| Nombre del Oftalmólogo: | | | | | |
| **Audición:** | | | **Sí** | | **No** |
| ¿Su hijo(a) sufre de un problema auditivo? | | |  | |  |
| ¿Tienes tubos colocados en el oído? | | |  | |  |
| ¿Sufre de infecciones y dolores del oído frecuentemente? | | |  | |  |
| ¿Falló un examen auditivo en la escuela? | | |  | |  |
| ¿Está bajo el cuidado de un especialista? | | |  | |  |
| ¿Utiliza un audífono? | | | | | |
| Nombre del médico: | | | | | |

**Seguro:**

**¿Cómo se le proporcionan los cuidados al estudiante? *Favor de poner una ✓ en lo aplicable a su hijo(a):***

Seguro Privado\_\_\_\_\_\_\_\_ Medicaid \_\_\_\_\_\_\_\_\_ CHIP \_\_\_\_\_\_\_\_\_\_ Obama Healthcare\_\_\_\_\_\_\_\_\_ No tiene seguro\_\_\_\_\_\_\_\_\_\_\_\_

Ultimo examen físico \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ultimo examen dental \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Servicios escolares:**

**¿Recibe su hijo alguno de los siguientes servicios en la escuela? *Favor de poner una ✓ en lo aplicable a su hijo(a):***

504 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Programa de Educación Especial: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Terapia del lenguaje \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dislexia \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Esta información se mantendrá confidencial, a menos de que surja una emergencia o la enfermera determine que el equipo de la escuela, el personal de transporte, o el que provee los cuidados primarios necesita saberla debido a preocupaciones específicas referentes a la salud de su hijo(a). Doy permiso de que se comparta esta información con el personal de la escuela y el proveedor de cuidados primarios, si es que surge una emergencia o la enfermera determina que hay necesidad de saberlo para asegurar la salud, la seguridad y el bienestar de mi hijo(a). Entiendo que es mi responsabilidad como padre/guardián el informar a los maestros y al personal de escuela las condiciones de salud que sufre mi hijo(a).Enfermera puede ponerse en contacto con el médico para clarificar el diagnóstico médico o la dosis del medicamento.**

**\*En caso de que haya una emergencia y no se me pueda localizar, yo, el que firma abajo, da su autorización a los oficiales del MISD para que tomen la acción necesaria para la salud de mi hijo(a). No se responsabilizará a MISD financieramente por el cuidado de emergencia y/o transporte de mi hijo(a).**

**Firma del Padre de Familia/Guardián *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fecha\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

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**MERCEDES INDEPENDENT SCHOOL DISTRICT**

****

**Medical Services**

**950 W 6th St, Mercedes, TX 78570 |956-825-5075**

**REQUEST FOR ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL**

Name of Student: Birthdate: Student I.D. #:

Grade: Phone #: Address:

Condition for which drug is to be given:

Medication:

Dosage and method of administration (please list special instructions, possible reactions, if any, etc.):

PLEASE NOTE: THE ABOVE MEDICATION MAY NOT BE SCHEDULED FOR OTHER THAN SCHOOL HOURS. IT MAY BE ADMINISTERED BY AN ASSIGNED UNLICENSED SCHOOL PERSONNEL. THE SCHOOL NURSE MAY CONTACT MY CHILD’S DOCTOR TO VERIFY DIAGNOSIS OR DOSAGE.

\*For asthma inhalers/nebulizer treatments **ONLY**: I authorize or do not authorize the school to send this medication home with my child on the last day of school. ***please circle one***

Physician’s Name (please print): Office Number:

Physician’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*By signing below, I authorize the school nurse and assigned unlicensed school personnel to administer the medication described above to my child. I understand it is my responsibility to inform the school nurse and teachers of any changes to the medication made by my child’s physician and to provide any special instructions for the administration of my child’s medication. I understand that my child cannot bring this medication to school. It must be brought by the parent or a consented adult. I understand that if this medication is not picked up by the last day of school, unless authorized above to be sent home for asthma inhalers/nebulizer treatments, it will be disposed of properly. If authorized above, I give consent for the school nurse or authorized school personnel to send the medication home to my child and understand that MISD is not liable for the medication sent home. I authorize the school nurse to contact my child’s doctor to verify diagnosis of the medication or dosage or time.*

Parent/Legal Guardian Signature Date

***Mercedes ISD does not discriminate on the basis of race, religion, color, national origin, gender, age or disability in providing education services, activities, and programs, including vocational programs, in accordance with Title VI of the Civil Rights Act of 1964, as amended; Title IX of the Educational Amendments of 1972; section 504 of the Rehabilitation Act of 1973, as amended.***

**SCHOOL NURSE USE ONLY:**

Filed in Nurses Office on: Filed By:

MM/DD/YYYY

**MERCEDES INDEPENDENT SCHOOL DISTRICT**

****

**SERVICIOS MEDICOS**

**950 W 6th St, Mercedes, TX 78570 |956-825-5075**

**Solicitud Para La Administración De Medicamentos Por El Personal De La Escuela**

Nombre de Estudiante: Fecha De Nacimiento: I.D. #:

Grado: Teléfono: Dirección:

La condición para que el medicamento esta ser dada:

El Medicamento:

La dosis y método de administración (instrucciones especiales, reacciones posibles, si cualquier, etc.):

NOTA: EL MEDICAMENTO SERA ADMINISTRADA DURANTE LAS HORAS DE ESCUELA NAMADAS. EL MEDICAMENTO PODRA SER ADMINISTRADA POR ALGUIEN MAS QUE LA ENFERMERA INDICA QUE NO NECESARMIAMENTE TIENE ENTRENAMINTO MEDICO. LA ENFERMERA TIENE MI PERMISO DE LLAMAR AL DOCTOR PARA ACLARAR EL DOSES OR DIAGNÓSTICO.

\*Para tratamientos de asma en el que se requiera inhalador/nebulizador **SOLAMENTE**: Yo authorizo o no authorizo a la escuela que mande este medicamento con mi hijo (a) en el último día del curso escolar. ***Por favor* *circule uno***

Nombre del Médico: Número de Oficina:

Firma del Médico: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fecha:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Al firmar abajo, yo autorizo a la enfermera y/o al personal sin licencia de la escuela para administrar medicamento mencionado a mi hijo/a. Entiendo que es mi responsabilidad informar a la enfermera de la escuela y a sus maestros en caso de algún cambio en el medicamento y de proveer las instrucciones de cómo este debe ser administrado. Entiendo que mi hijo(a) no puede llevar este medicamento a la escuela. Yo comprendo que si este medicamento no es recogido por el último día de la escuela, a menos que se autorice anteriormente para ser enviado a casa para inhaladores de asma / tratamientos nebulizadores, se eliminará correctamente. Si se autoriza anteriormente, yo doy mi consentimiento para que la enfermera de la escuela o el personal de la escuela autorizado de mandar el medicamento a mi hijo(a) y entiendo que MISD no es responsable por el medicamento enviado a casa.*

Firma de Padre(s) o Tutor(s) Fecha

***Mercedes ISD no discrimina por motivos de raza, religión, color, origen nacional, sexo, edad o discapacidad en la prestación de servicios educativos, actividades y programas, incluyendo programas vocacionales, de acuerdo con el Título VI de la Ley de Derechos Civiles de 1964, como acordado; Título IX de las Enmiendas Educativas de 1972; la sección 504 de la Ley de Rehabilitación de 1973, según enmendada.***

**SCHOOL NURSE USE ONLY:**

Filed in Nurses Office on: Filed By:

MM/DD/YYYY

**MERCEDES INDEPENDENT SCHOOL DISTRICT**

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**MEDICAL SERVICES**

**950 W 6th St, Mercedes, TX 78570 |956-825-5075**

**ADVISING OF MEDICATION POLICY IN SCHOOL**

**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dear Parent or Guardian:**

In compliance with Texas State Law and Mercedes ISD District Policy, the following restrictions apply to the taking of medicine by students while at school:

1. All medicine is to be brought to and kept in the school nurse’s office by the parent or guardian. For the exception of rescue inhalers and EpiPens provided by a plan from the doctor that includes a doctor’s consent for child to carry medication on school grounds.
2. Prescription medicine must be in the original container and with the pharmacy label for that student.
3. No over the counter medications will be given unless provided with a doctor’s prescription. Medications that are brought from foreign countries such as ***Mexico*** cannot be given by school personnel.
4. Medications scheduled before 8:00 a.m. and after school are to be given by parents. Medications to be given in school will be those prescribed three times or more and medications ordered at a specific school hour. *Medications prescribed daily and twice a day should be given at home.*
5. If a prescription medicine must be given during the school day, it must be accompanied by a note signed by a parent or guardian giving authorized school personnel to administer medication with information of the last dose that was given, next dose scheduled and including name of medicine. The school nurse has the medication form to be signed by parent if medication will be given the whole year.
6. Medication will be given as prescribed by the doctor. For example; if the medication is prescribed three times a day; the first dose should be given at home in the morning before school and the next dose during school, then the last dose at home in the evening. Medication prescribed as needed, will be given if the child requests for the medication during school taking into account the last time he/she took the medication.
7. No medication that has an outdated expiration date will be given at school. Medications should be current from the day it was prescribed.
8. School personnel will not provide any oral medicine, including Tylenol, unless it is provided by a doctor’s prescription, in the appropriate manner as stated above.

These restrictions are necessary for protection of the health and safety of your child. We will appreciate your cooperation in this manner. If you have any questions, please contact the school nurse at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Respectfully,

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School Nurse School

**MERCEDES INDEPENDENT SCHOOL DISTRICT**

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**SERVICIOS MEDICOS**

**950 W 6th St, Mercedes, TX 78570 |956-825-5075**

**PÓLIZA DE ADMINISTRACIÓN DE MEDICAMENTOS DENTRO DEL PLANTEL ESCOLAR**

**Fecha: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Estimado Padre de Familia o Guardián:**

Les comunicamos que, en cumplimiento con la Ley Estatal de Texas y la Póliza del Mercedes Independent School District, las siguientes restricciones han sido designadas para la administración de medicamentos a estudiantes mientras estén en la escuela:

1. Todos los medicamentos debe ser traídos por los padres y guardado en la oficina de la enfermera de la escuela, excepto los inhaladores de rescate o plumas de epinefrina recetados por un doctor con un plan de acción indicando que el alumno lo puede traer consigo.
2. Los medicamentos recetados deben estar en su recipiente original y con la etiqueta de la farmacia extendida a nombre del estudiante que traiga las medicinas a la escuela.
3. No se proporcionará ningún medicamento a menos que haya sido obtenido por medio de una receta médica. Los medicamentos que son comprados en o traídos de otros países, como México, no serán ni podrán ser administrados por el personal escolar.
4. Los medicamentos que deben ser tomados antes de las 8:00 a.m. y al término del día escolar deberán ser administrados por los padres de familia. Los medicamentos que se administrarán en la escuela serán aquellos que sean recetados tres veces o más y los prescritos para ser administrados a una hora escolar ya determinada. *Los medicamentos que sean recetados para ser administrados diariamente una o dos veces al día se administrarán en casa.*
5. En caso de que un medicamento deba ser administrado durante el día escolar, deberá ser acompañado por una nota firmada por el padre de familia o guardián dando su autorización al personal escolar para administrar los medicamentos, siempre y cuando contenga la información de la última dosis dada, la siguiente dosis programada, y el nombre de la medicina. La enfermera de la escuela le puede proporcionar el formulario para medicinas, con el fin de que los padres de familia los firmen, si es que el medicamento va a ser administrado durante todo el año escolar.
6. El medicamento será administrado según como lo recete el doctor. Por ejemplo: si el medicamento debe administrarse tres veces al día; entonces, la primera dosis se administrará en la casa en la mañana antes de venir a la escuela; la siguiente dosis durante clases; y, finalmente, la última dosis en la casa. Medicamentos recetados según sean necesarios, serán proporcionado a él (la) alumno(a) si es que lo pide durante clases tomando en cuenta la última vez que él o ella tomó el medicamento.
7. No se administrará en la escuela ningún medicamento que muestre la fecha caducada. El medicamento deberá mostrar la fecha al corriente desde el momento en que fue recetado.
8. El personal escolar no podrá administrar ningún medicamento, ni siquiera Tylenol, a menos de que haya sido recetado por un doctor de la manera apropiada como antes mencionado.

Estas restricciones son necesarias para la protección de la salud y seguridad de su hijo(a). Mucho agradeceremos su cooperación en este asunto y de la manera como se describe arriba. Si tiene alguna duda o pregunta, favor de comunicarse con la enfermera de la escuela al \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Atenemente,

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Enfermera Escolar Fecha

**MERCEDES INDEPENDENT SCHOOL DISTRICT**

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**MEDICAL SERVICES**

**950 W 6th St, Mercedes, TX 78570 |956-825-5075**

**Medical Regulations**

**HOW TO GIVE MEDICATIONS**

Medications that your child needs during the school year can usually be given at home.

|  |  |
| --- | --- |
| Once a day/daily | Before or after school |
| Twice a day | Before school and in the evening |
| Three times a day | Before school, after school, and at bedtime |

Medications before 8:00 a.m. or afterschool will be given at home. Medications that are needed to be given with food can be given at home with crackers or milk.

**PERMISSION NOTE IS REQUIRED**

To give medication prescribed by the doctor, we must have a written note signed by the student’s parent or legal guardian. You may send a handwritten note from home that includes the last dose given at home and medication name, or a form is available at the school nurse’s office. If the medication is not within the school medication policy, the school nurse may contact you to inform you that the medication may not be given. All medications will be given out by the school nurse or designated school personnel

**KEEP MEDICATIONS IN THEIR PROPER CONTAINERS**

All medications must be in their original containers; prescription medications must have a pharmacy label. We are not allowed to give prescription medications labeled with one student’s name to any other student, even a brother or sister.

**MEDICATIONS GIVEN DURING SCHOOL**

Medications that will be given during school are those prescribed by a doctor and with a frequency of every 4 hours or less or ordered at a specific school hour.

**FOR NEBULIZER TREATMENTS**

If a child needs a nebulizer treatment during the school day, please provide the school nurse with the child’s mask and tubing as we do not provide that equipment for any student. Provide medication vials in the original container to prevent your child from not receiving the medication.

**ALL MEDICATIONS BELONG IN NURSE’S OFFICE**

Students may not have any medications with them during school hours for the exception of rescue inhalers or EpiPens provided with a plan by the doctor stating they may carry it. Unapproved medications will be confiscated by the school nurse and will be returned at the end of the day if permissible. All medications needed during the school hours must be brought by the parent/guardian to the school nurse due to safety laws. A child is not allowed to transport or have possession of a controlled medication such as for ADHD. If a medication is in the nurse’s office and not picked up by the last day of school, it will be discarded properly by the school nurse.

**NO SAMPLES, MEDICATIONS FROM MEXICO, OR**

**OVER THE COUNTER MEDICATIONS**

All medications must be prescribed by a physician. District policy does not allow us to give sample medications (unless your health care provider sends a prescription with specific medication administration instructions including dosage and frequency), herbal products or dietary supplements, or medications from another country such as Mexico. No over the counter medications will be given unless provided with a doctor’s prescription.

**INSTRUCTIONS ARE IMPORTANT**

Medications will only be given according to the instructions on the label. If a medication is prescribed as needed the medication will only be given if the child requests for the medication during school hours.

**FIRST DOSE MUST BE GIVEN AT HOME**

The first dose of a brand new medication must be given at home to ensure child does not have an allergic reaction during school.

\_\_\_\_\_\_\_\_\_\_\_\_**Parent Initials**

**ILLNESS**

We cannot keep your child in school when they might be contagious to others or when they are too sick to do their school work. There are Texas Health Department laws that require us to protect all students from infectious diseases. Examples are: Fever over 100 degrees, lice, pink eye, flu, scabies, diarrhea, etc. There may be times where your child will be excluded from school until they see a doctor. They can return back to school once their doctor releases them. Please send that release to school with your child. Please be aware that the school will only accept the child on the release date indicated from the doctor’s excuse. For more information on communicable diseases exclusion guidelines visit: <http://www.dshs.states.tx.us/idcu/health/schools_childcare/resources/ChildCareChartNotes.pdf> . Note that the school is not responsible for the transportation of your child. It is your responsibility to provide transportation if your child needs to be picked up from school. If you are not sure if your child should be sent to school you may also contact the school nurse to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

\_\_\_\_\_\_\_\_\_\_\_\_**Parent Initials**

**VACCINATIONS**

All students must be up-to-date with their vaccinations. A child cannot be in school when a shot is due. The school may call you to inform you that the child cannot return to school until the child is vaccinated. If proof of vaccination is not provided the school may withdraw your child from school until proper documentation of immunization (s) or a valid medical or conscientious exemption is/are on file. A medical exemption from a doctor is only valid for one year and conscientious exemption for two years. Please visit <http://dshs.states.tx.us/IMMUNIZE/> for more information.

\_\_\_\_\_\_\_\_\_\_\_\_**Parent Initials**

**Student’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_\_\_\_\_\_\_\_**

**Parent Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MERCEDES INDEPENDENT SCHOOL DISTRICT**

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**SERVICIOS MÉDICOS**

**950 W 6th St, Mercedes, TX 78570 |956-825-5075**

**Normas de Seguridad Médica**

**¿CÓMO ADMINISTRAR MEDICAMENTOS?**

Los medicamentos que su hijo/hija necesite durante el año escolar, por lo general, suelen darse en la casa.

|  |  |
| --- | --- |
| Una vez al día/Una a diario | Antes o después de clases |
| Dos veces al día | Antes de clases y en la tarde |
| Tres veces al día | Antes, después y a la hora de  ir a la cama. |

Medicamentos necesitados antes de las 8:00 a.m. o al término de clases serán dados en la casa. Los medicamentos que necesitan administrarse con alimentos pueden darse en la casa con galletas o leche.

**SE REQUIERE NOTA DE AUTORIZACIÓN**

Para poder administrar el medicamento que recetó el doctor, debemos tener una nota por escrito firmada por el padre del estudiante o su guardián legal. Pueden enviar una nota escrita a mano que indique la última dosis administrada en casa y el nombre de la medicina. O, puede obtener en la oficina de la enfermera escolar una forma para este asunto. Si el medicamento no está dentro de la política medicinal escolar, la enfermera se comunicará con usted para informarle que el medicamento pudiera no ser administrado. Todos los medicamentos serán dados por la enfermera escolar o el personal escolar asignado.

**MANTENGA LAS MEDICINAS EN SU ENVOLTURA ORIGINAL**

Todos los medicamentos deben estar en sus envolturas originales; las medicinas que sean recetadas deben tener una etiqueta con el nombre de la farmacia. No estamos autorizados

para administrar medicamentos etiquetados con el nombre de un alumno a cualquier otro

estudiante, aún siendo hermano o hermana de este alumno.

**MEDICAMENTOS ADMINISTRADOS**

**DURANTE CLASES**

Los medicamentos que serán administrados durante clases son los que han sido recetados por un doctor y con una frecuencia de cada 4 horas o menos, o prescritos a una hora específica.

**TRATAMIENTO NEBULIZADOR**

En caso de que un alumno necesite utilizar el nebulizador durante horas escolares, favor de proporcionar la máscara y el tubo necesario pues la escuela no facilita este equipo a estudiantes. Favor de mandar todos los medicamentos en los envases originales para asegurar que su hijo/a reciba su medicamento.

**TODA CLASE DE MEDICAMENTOS DEBERÁ PERMANECEREN LA ENFERMERíA**

Los alumnos no podrán traer medicamentos durante las clases, a excepción de inhaladores de rescate o plumas de epinefrina recetados por un doctor con un plan de acción indicando que el alumno lo puede traer consigo. Medicamentos que no han sido aprobados serán confiscados por la enfermera escolar y serán regresados al terminar las clases, si es permitido. Todos los medicamentos necesarios durante el horario escolar, los padres deben traer la medicina a la enfermera de la escuela. No se permite que un alumno cargue o traiga consigo un medicamento controlado, tal como para ADHD. Si un medicamento está en la oficina de la enfermera y no se recoge para el último día de clases, la enfermera de la escuela lo desechará adecuadamente.

**NO SE ACEPTAN MUESTRAS MEDICINALES, MEDICAMENTOS DE MÉXICO, O COMPRADOS SIN RECETA**

Todos los medicamentos deben ser recetados por un doctor. La política de la escuela no nos permite dar muestras de medicamentos (a menos que su proveedor médico envíe una receta con las instrucciones específicas de administración del medicamento, inclusive la dosis y frecuencia), productos a base de hierbas o suplementos dietéticos, o medicinas de otros países tales como México. La medicina comprada sin receta se administrará solamente si viene acompañada por un comprobante del doctor.

**LAS INDICACIONES SON IMPORTANTES**

Los medicamentos serán administrados de acuerdo a las indicaciones dadas en la etiqueta. Si el medicamento se receta “Como sea necesario”, el medicamento será dado si el

alumno solicita el medicamento durante las horas de clase.

**LA PRIMERA DOSIS DEBE ADMINISTRARSE EN CASA**

La primera dosis de un medicamento nuevo debe ser administrada en casa, con el fin de asegurarse de que su hijo/a no presente o tenga

una reacción alérgica durante las clases.

\_\_\_\_\_\_\_\_\_\_\_\_**Iniciales del Padre**

**ENFERMEDAD**

Su hijo/a no puede quedarse en la escuela cuando tenga una enfermedad que pudiera ser contagiosa a otros o cuando se encuentre tan enfermo/a que no puede cumplir con sus deberes escolares. Según las leyes estipuladas por el Departamento de Salud en Texas, éstas requieren que protejamos a los estudiantes de enfermedades contagiosas. Por ejemplo: fiebre más alta de 100 grados, piojos, conjuntivitis, gripe, sarna, diarrea, etc. Se podrá presentar la necesidad de prohibirle la entrada a clases hasta que vaya a ver a un doctor. Puede regresar a clases toda vez que su doctor lo dé de alta. Favor de enviar la excusa del doctor a la escuela con su hijo. Tome nota que la escuela le permitirá a su hijo/a la entrada a clases en la fecha indicada en la excusa del doctor. Para mayores informes de las normas acerca de las exclusiones debido a enfermedades contagiosas, favor de visitar el sitio: <http://www.dshs.states.tx.us/idcu/health/schools_childcare/resources/ChildCareChartNotes.pdf> . Tome nota que la escuela no se hace responsable por el transporte de su hijo/a. Es su responsabilidad proporcionarle el transporte si su hijo/a necesita ser recogido/a de la escuela. Si no están seguros de que su hijo/a no debería ir a la escuela, también puede comunicarse con la enfermera de la escuela al: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

\_\_\_\_\_\_\_\_\_\_\_\_ **Iniciales del Padre o la Madre**

**VACUNAS**

Todos los estudiantes deben estar al día con sus vacunas. Un alumno no puede estar en la escuela cuando se vence una de las vacunas. La escuela puede llamarle para decirle que su hijo no puede regresar a la escuela hasta que sea vacunado. Si la cartilla de vacunación no es entregada su hijo/a puede ser sacado de la escuela hasta que la documentación apropiada o una forma válida de excepción o consentimiento médica sea archivada. Todas las formas de excepción son validas solo por un ao y las formas de consentimiento por 2 años. Para mayores informes, favor de visitar el sitio: <http://dshs.states.tx.us/IMMUNIZE/>.

\_\_\_\_\_\_\_\_\_\_\_\_ **Iniciales del Padre**

**Nombre del Alumno/a: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fecha de Nacimiento:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grado : \_\_\_\_\_\_\_\_\_\_**

**Firma del Padre: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fecha**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MERCEDES INDEPENDENT SCHOOL DISTRICT**

****

**MEDICAL SERVICES**

**950 W 6th St, Mercedes, TX 78570 |956-825-5075**

**MEDICAL REFERRAL FORM**

**Campus Name: Date:**

Dear Parent or Guardian:

The health services given by the Mercedes Independent School District includes observation by the classroom teacher and further health appraisal by the school nurse.

Based on our observation of your child, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ on the date of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

School Nurse directs your attention to the recommended medical observation given on this form.

The School Nurse earnestly desires to cooperate with you in maintaining the best state of health for this student. It is suggested that you consider this report thoroughly and consult your physician concerning the observation in which further investigation is suggested.

Please feel free to contact the Office of Safe Schools/Student Services for any questions or advice as needed at

(956) 825-5072 ext 6002.

RECOMMENDED MEDICAL OBSERVATION OF SCHOOL NURSE

Signature of School Nurse Date

**PHYSICIAN USE ONLY**

Dear Physician,

Please complete the area below for the child’s school record.

Diagnosis:

Treatment:

Restrictions for school/PE:

Student may return to school on: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MM/DD/YYYY

Signature of Physician Date

**(ATTENTION PARENT/GUARDIAN: PLEASE RETURN THIS FORM TO THE SCHOOL NURSE)**

***Mercedes ISD does not discriminate on the basis of race, religion, color, national origin, gender, age or disability in providing education services, activities, and programs, including vocational programs, in accordance with Title VI of the Civil Rights Act of 1964, as amended; Title IX of the Educational Amendments of 1972; section 504 of the Rehabilitation Act of 1973, as amended.***

**MERCEDES INDEPENDENT SCHOOL DISTRICT**

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**SERVICIOS MEDICOS**

**950 W 6th St, Mercedes, TX 78570 |956-825-5075**

**SOLICITUD PARA ATENCION MÉDICA**

**Nombre de Escuela: Fecha:**

Estimado padre o tutor:

Los servicios de salud propuesta por el Distrito Escolar Independiente de Mercedes incluye la observación por el maestro y nueva evaluación de la salud por la enfermera de la escuela.

Sobre la base de nuestra observación de su hijo, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ en la fecha de \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, enfermera de la escuela dirige su atención a la observación médica recomendada en este formulario.

La enfermera sinceramente desea cooperar con usted para mantener el mejor estado de salud para este estudiante. Se sugiere que se tiene en cuenta este informe a fondo y consulte a su médico acerca de la observación en la que se sugiere una mayor investigación.

En ponerse en contacto con la enfermera para cualquier consulta o asesoramiento, según sea necesario al (956) 825-5072 ext 6002.

OBSERVACION DE LA ENFERMERA

Firma de la enfermera de la Escuela Date

**USO DEL MÉDICO**

Estimado Médico,

Favor de completar el área debajo para el record de la escuela de este estudiante.

Diagnóstico:

Tratamiento:

Restricciones:

El estudiante puede regresar a la escuela el: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MM/DD/YYYY

Firma del Médico Fecha

**(ATENCIÓN PADRES/TUTORES: POR FAVOR DEVUELVA ESTA FORMA A LA ENFERMERA DE LA ESCUELA)**

***Mercedes ISD no discrimina por motivos de raza, religión, color, origen nacional, sexo, edad o discapacidad en la prestación de servicios educativos, actividades y programas, incluyendo programas vocacionales, de acuerdo con el Título VI de la Ley de Derechos Civiles de 1964, como acordado; Título IX de las Enmiendas Educativas de 1972; la sección 504 de la Ley de Rehabilitación de 1973, según enmendada.***

**MERCEDES INDEPENDENT SCHOOL DISTRICT**

****

**MEDICAL SERVICES**

**950 W 6th St, Mercedes, TX 78570 |956-825-5075**

**REQUIRED IMMUNIZATIONS**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
| *Student Name* |  | *I.D. Number* |  | *Date* |

*Dear Parent(s) or Guardian(s),*

*As part of the Mercedes I.S.D. health program the school nurse must make sure that all children are up to date with their immunizations. The Texas Department of Health Services Immunization Requirements indicates your child needs the shot(s) that is/are checked off below:*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 🞎 | HEPATITIS B (SERIES OF 3 SHOTS) | 🞎 | DPT | 🞎 | MCV4 |
| 🞎 | HEPATITIS A (SERIES OF 2 SHOTS) | 🞎 | POLIO |  |  |
| 🞎 | MMR | 🞎 | HIB |  |  |
| 🞎 | TD/TDAP | 🞎 | PPD/TB SKIN TEST |  |  |
| 🞎 | VARICELLA (CHICKEN POX) | 🞎 | PCV |  |  |

\*Please keep in mind a parent or guardian must be present at all immunizations.

Upon completion, please send the immunization card to the school nurse immediately, so this information can be recorded on his/her student record.

***Parent/Guardian Acknowledgement:***

*I understand that if proper immunization records have not been received by Mercedes I.S.D., my child will be withdrawn from school until the right documentation of immunization(s) or a valid medical or conscientious exemption is/are on file.*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School Nurse Signature Parent(s) or Guardian(s) Signature

The immunizations can be given at the following addresses:

|  |  |  |
| --- | --- | --- |
| Hidalgo County Health Center  1901 N. Bridge  Weslaco, TX 78596  956-968-7541 | Nuestra Clínica Del Valle  1500 1st St.  Mercedes, TX 78570  956-565-3191 | Benjamin Salinas, MD  1609 N. International Blvd. Suite C  Weslaco, TX 78596  956-565-2727 |



***“To Keep Your Child Healthy Is Our Main Concern”***

***Mercedes ISD does not discriminate on the basis of race, religion, color, national origin, gender, age or disability in providing education services, activities, and programs, including vocational programs, in accordance with Title VI of the Civil Rights Acts of 1964, as amended; Title IX of the Educational Amendments of 1972; section 504 of the Rehabilitation Act of 1973, as amended.***

**MERCEDES INDEPENDENT SCHOOL DISTRICT**

****

**SERVICIOS MEDICOS**

**950 W 6th St, Mercedes, TX 78570 |956-825-5075**

**INMUNIZACIONES NECEARIAS**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
| *Nombre del Estudiante* |  | *Numero de Identificación* |  | *Fecha* |

*Estimado Padre(s) o Tutor(s),*

*Parte del programa de salud de Mercedes I.S.D. es que la enfermera de la escuela debe asegurarse de que todos los niños/niñas estén al día con sus vacunas. El Departamento de Servicios de Salud Requisitos de Inmunización de Texas indican que su hijo/hija necesita el disparo(s) que es/son la(s) siguiente vacunas:*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 🞎 | HEPATITIS B (SERIES OF 3 SHOTS) | 🞎 | DPT | 🞎 | MCV4 |
| 🞎 | HEPATITIS A (SERIES OF 2 SHOTS) | 🞎 | POLIO |  |  |
| 🞎 | MMR | 🞎 | HIB |  |  |
| 🞎 | TD/TDAP | 🞎 | PPD/TB SKIN TEST |  |  |
| 🞎 | VARICELLA (CHICKEN POX) | 🞎 | PCV |  |  |

\*Por favor, tenga en cuenta que en padre o tutor debe estar presente en todas las vacunas.

Al terminar, favor de mandar la tarjeta de vacunación a la enfermera de la escuela inmediatamente, así que esta información tiene que ser registrado en el registro del estudiante.

***Agradecimientos del Padre/Tutor:***

*Yo entiendo que si un registro adecuado de vacunación no se han recibido por Mercedes I.S.D., mi hijo será retirado de la escuela hasta que el documentación de la derecha de la inmunización(s) o una exención médica o de conciencia valida es/son recibidos.*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Firma del Enfermera de la Escuela Firma de Padre(s) o Tutor(s)

Las inmunizaciones se pueden dar n las siguientes direcciones:

|  |  |  |
| --- | --- | --- |
| Hidalgo County Health Center  1901 N. Bridge  Weslaco, TX 78596  956-968-7541 | Nuestra Clínica Del Valle  1500 1st St.  Mercedes, TX 78570  956-565-3191 | Benjamin Salinas, MD  1609 N. International Blvd. Suite C  Weslaco, TX 78596  956-565-2727 |



***“Para Conservar Su Salud Es Nuestro Principal Interés”***

***Mercedes ISD no discrimina por motivos de raza, religión, color, origen nacional, sexo, edad o discapacidad en la prestación de servicios educativos, actividades y programas, incluyendo programas vocacionales, de acuerdo con el Título VI de la Ley de Derechos Civiles de 1964, como acordado; Título IX de las Enmiendas Educativas de 1972; la sección 504 de la Ley de Rehabilitación de 1973, según enmendada.***

**MERCEDES INDEPENDENT SCHOOL DISTRICT**

****

**MEDICAL SERVICES**

**950 W 6th St, Mercedes, TX 78570 |956-825-5075**

**CONJUNCTIVITIS (PINK EYE)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
| *Student Name* |  | *I.D. Number* |  | *Date* |

*Dear Parent(s) or Guardian(s),*

*We understand there are a number of cases of conjunctivitis everywhere, especially in school. Conjunctivitis or pink eye is an inflammation/irritation of the eye. It can be caused by allergies or chemicals, medication, gas, fumes, chlorine from a swimming pool, etc. Infectious conjunctivitis (viral or bacterial) is contagious. It spreads from person to person by direct contact with the secretions or discharge from the eyes of someone who is infected.*

*Signs and symptoms to watch for are: redness, itching, or pain. There is usually a discharge which may be thick (yellow or green) or watery. The eyelids maybe swollen and slightly pink and the lashes may be crusted together when the child awakens in the morning.*

*Prevention and treatment: bacterial infections are treated with antibiotics, some taken by mouth and others as drops or ointment applied directly to the eye. Children with infectious conjunctivitis are considered contagious. Careful hand washing is important in preventing the spread of disease.*

*If you suspect infectious conjunctivitis, please keep your child home and contact your physician. If your child is diagnosed with conjunctivitis and receives treatment, he or she must be cleared by your physician before they can return to school.*

*Sincerely,*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*School Nurse Telephone*

**PHYSICIAN USE ONLY**

Dear Physician,

Please complete the area below for the child’s school record. It is necessary in order for the child to return to school.

Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student may return to school on: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MM/DD/YYYY

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Physician Date

**(ATTENTION PARENT/GUARDIAN: PLEASE RETURN THIS FORM TO THE SCHOOL NURSE)**

**MERCEDES INDEPENDENT SCHOOL DISTRICT**

****

**SERVICIOS MEDICOS**

**950 W 6th St, Mercedes, TX 78570 |956-825-5075**

**CONJUNCTIVITIS (INFECCION DE LOS OJOS)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
| *Nombre del Estudiante* |  | *Numero de Identificación* |  | *Fecha* |

*Estimado Padre(s) o Tutor(es),*

*Entendemos que hay una serie de casos de conjuntivitis en todas partes, especialmente en la escuela. Conjuntivitis es una inflamación/ irritación del ojo. Puede ser causada por alergias o químicos, medicamentos, gases, humos, cloro de una piscina, etc. conjuntivitis infecciosa (viral o bacteriana) es contagiosa. Se propaga de persona a persona por contacto directo con las secreciones o la descarga de los ojos de alguien que está infectado.  
  
Los signos y síntomas a tener en cuenta son: enrojecimiento, picazón o dolor. Por lo general hay una descarga que puede ser de espesor (amarillo o verde) o acuosa. Los párpados hinchados y tal vez un poco de color rosa y las pestañas se pueden costra juntos cuando el niño se despierta en la mañana.  
  
Prevención y tratamiento: infecciones bacterianas se tratan con antibióticos, algunas tomadas por la boca y otros en forma de gotas o ungüentos aplicados directamente a los ojos. Los niños con conjuntivitis infecciosa se consideran contagiosos. Lavado cuidadoso de las manos es importante para prevenir la propagación de enfermedades.  
  
Si usted sospecha que la conjuntivitis infecciosa, por favor mantenga a su hijo a casa y ponerse en contacto con su médico. Si su niño es diagnosticado con la conjuntivitis y recibe atención, él o ella debe ser limpiado por su médico antes de que puedan volver a la escuela.*

*Sinceramente,*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Enfermera de la Escuela Teléfono*

**USO DEL MÉDICO**

Estimado Médico,

Por favor complete el área debajo de récord de la escuela del estudiante. Es necesario para que regrese a la escuela.

Diagnostico: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tratamiento: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

El estudiante puede regresar a la escuela el: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MM/DD/YYYY

Firma del Médico Fecha

**(ATENCIÓN PADRES/TUTORES: POR FAVOR DEVUELVA ESTA FORMA A LA ENFERMERA DE LA ESCUELA)**

**MERCEDES INDEPENDENT SCHOOL DISTRICT**

****

**TB QUESTIONNAIRE**

Name of Child\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Campus administering questionnaire\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_\_\_\_\_\_\_\_\_

Tuberculosis (TB) is a disease caused by TB germs and is usually transmitted by an adult person with active TB lung disease. It is spread to another person by coughing or sneezing TB germs into the air. These germs may be breathed in by the child.

Adults who have active TB disease usually have many of the following symptoms: cough for more than two weeks duration, loss of appetite, weight loss of ten or more pounds over a short period of time, fever, chills and night sweats.

A person can have TB germs in his or her body but not have active TB disease (this is called latent TB infection or LTBI).

Tuberculosis is preventable and treatable. TB skin testing (often called the PPD or Mantoux test) is used to see if your child has been infected with TB germs. No vaccine is recommended for use in the United States to prevent tuberculosis. The skin test is not a vaccination against TB.

We need your help to find out if your child has been exposed to tuberculosis.

|  |  |  |  |
| --- | --- | --- | --- |
| Place a mark in the appropriate box: | Yes | No | Don't Know |
| TB can cause fever of long duration, unexplained weight loss, a bad cough (lasting over two weeks), or coughing up blood. As far as you know:  Has your child been around anyone with any of these symptoms or problems? or  Has your child had any of these symptoms or problems? or  Has your child been around anyone sick with TB? |  |  |  |
| Was your child born in Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe or Asia? |  |  |  |
| Has your child traveled in the past year to Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe or Asia for longer than 3 weeks?  If so, specify which country/countries? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |
| To your knowledge, has your child spent time (longer than 3 weeks) with anyone who is/has been an intravenous (IV) drug user, HIV-infected, in jail or prison or recently came to the United States from another country? |  |  |  |

Has your child been tested for TB? Yes\_\_\_ (if yes, specify date \_\_\_\_/\_\_\_\_) No\_\_\_

Has your child ever had a positive TB skin test? Yes\_\_\_ (if yes, specify date \_\_\_\_/\_\_\_\_) No\_\_\_

**Parent Signature:** x **Date:**

**For school/healthcare provider use only**

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

PPD administered Yes\_\_\_ No\_\_\_

If yes,

Date administered \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ Date read \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_ Result of PPD test \_\_\_\_\_\_\_\_\_\_ mm response

Type of service provider (i.e. school, Health Steps, other clinics) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PPD provider \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Printed Name

Provider phone number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ County \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If positive, referral to healthcare provider Yes\_\_\_\_\_\_ No\_\_\_\_\_\_

If yes, name of provider \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



EF12-11494 TB Questionnaire for Children (Rev. 08/04)

**MERCEDES INDEPENDENT SCHOOL DISTRICT**

****

**CUESTIONARIO DE TUBERCULOSIS**

Nombre del niño o niña \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fecha de nacimiento \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Escuela \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fecha \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Grado: \_\_\_\_\_\_\_\_\_\_\_

La Tuberculosis (TB) es una enfermedad causada por gérmenes de TB y en la mayoría de los casos es trasmitida por una persona adulta con tuberculosis pulmonar activa. Se transmite a otra persona por la tos y por el estornudo al expelir gérmenes de TB al aire que pueden ser respirados por los niños.

Los adultos que tienen la enfermedad activa casi siempre tienen varios de los siguientes síntomas: tos con duración de más de dos semanas, pérdida de apetito, pérdida de peso de diez libras o más en un período corto de tiempo, fiebre, escalofríos y sudores nocturnos.

Una persona puede tener gérmenes de TB en su cuerpo pero no tener la enfermedad activa. Esto se llama infección latente de TB (o LTBI por su sigla en inglés).

La TB es prevenible y curable. La prueba tuberculínica, también llamada PPD o prueba de Mantoux, se utiliza para saber si su niño o niña ha sido infectado/a con el germen de TB. No se recomienda ninguna vacuna para prevenir la tuberculosis. La prueba tuberculínica no es una vacuna contra la tuberculosis.

Necesitamos de su ayuda para saber si su niño/niña ha sido expuesto/a la tuberculosis.

|  |  |  |  |
| --- | --- | --- | --- |
|  | Sí | No | No se sabe |
| La tuberculosis puede causar fiebre de larga duración, pérdida de peso inexplicable, tos severa (con más de dos semanas de duración), o tos con sangre. ¿Es de su conocimiento si:  Su niño o niña ha estado cerca de algún adulto con esos síntomas o problemas?  Su niño o niña ha tenido algunos de estos síntomas o problemas?  Su niño o niña ha estado cerca de alguna persona enferma de tuberculosis? |  |  |  |
| ¿Su niño o niña nació en México en o cualquier otro país de América Latina, el Caribe, África, Europa Oriental o Asia? |  |  |  |
| ¿Su niño o niña viajó a México o a cualquier otro país de América Latina, el Caribe, África, Europa Oriental o Asia durante el último año por más de 3 semanas?  Si su respuesta es positiva, favor de especificar a qué país o países: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |
| ¿Es de su conocimiento, si su niño o niña pasó un tiempo (más de 3 semanas) con alguna persona que es o ha sido usuario de droga intravenosa (IV), infectado por VIH, en la prisión, o haya llegado recientemente a los Estados Unidos? |  |  |  |

¿A su niño o niña se le ha realizado la prueba tuberculínica recientemente? Sí\_\_\_ (si sí, especifique la fecha \_\_\_\_/\_\_\_\_) No\_\_\_

¿Su niño o niña alguna vez tuvo reacción positiva a la tuberculina? Sí\_\_\_ (si sí, especifique la fecha \_\_\_\_/\_\_\_\_) No\_\_\_

**Firma de Padre:** x **Fecha:**

**Solamente para uso de la escuela o del proveedor de servicios médicos**

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

¿Se administró PPD? Sí\_\_\_ No\_\_\_

Si sí,

Fecha en que fue administrada\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Fecha de lectura \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_ Resultado de la prueba\_\_\_\_\_ mm

Tipo de proveedor de servicio (ej.: escuela, Health Steps, otras clínicas) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Administrador de PPD \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Firma Nombre en letra de molde (imprenta)

Número de teléfono del administrador de PPD \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ciudad\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Condado\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Si resultó positivo, ¿se refirió al proveedor de servicios de salud? Sí\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_

Si sí, nombre del proveedor (médico o clínica, etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**MERCEDES INDEPENDENT SCHOOL DISTRICT**

****

**MEDICAL SERVICES**

**950 W 6th St, Mercedes, TX 78570 |956-825-5075**

**HEAD INJURY INFORMATION SHEET**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dear Parent(s) or Guardian(s),

As per our phone call, you were informed that today your child, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, received an injury to the head. As you are aware, your child was seen in my office and had no problems at the time, but you should watch for any of the following symptoms:

1. Severe Headache
2. Excessive drowsiness
3. Nausea and or vomiting
4. Double vision or pupils of different sizes
5. Loss of muscle coordination such as following down, walking strangely, or staggering
6. Any unusual behavior such as being confused, breathing irregularly, or being dizzy
7. Convulsion
8. Bleeding or discharge from an ear

Please contact your physician or take your child to the emergency room if you notice any of the symptoms above.

Sincerely,

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School Nurse Telephone

**INFORMACIÓN SOBRE LESIONES DE CABEZA**

Estimado padre (s) o tutor (s),

Hoy nuestra llamada telefónica, informó de que su hijo, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, recibió una lesión en la cabeza. Como es de su conocimiento, su hijo fue visto en mi oficina y no tuvo problemas en el momento, pero se debe ver para cualquiera de los siguientes síntomas:

1) Dolor de cabeza severo  
2) somnolencia excesiva  
3) Las náuseas y los vómitos  
4) Visión doble o alumnos de diferentes tamaños  
5) La pérdida de la coordinación muscular, tales como seguir abajo, caminar de forma extraña, o escalonamiento  
6) Cualquier comportamiento inusual, como ser confundido, respiración irregular, o estar mareado  
7) Convulsión  
8) El sangrado o secreción del oído

Por favor, póngase en contacto con su médico o lleve a su hijo a la sala de emergencia si usted nota cualquiera de los síntomas antes mencionados.

Atentamente,

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Enfermera de la Escuela Teléfono

**MERCEDES INDEPENDENT SCHOOL DISTRICT**

****

**MEDICAL SERVICES**

**950 W 6th St, Mercedes, TX 78570 |956-825-5075**

**NOTIFICATION OF INCIDENT AT SCHOOL**

**Your child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_was involved in an incident at school.**

**Date incident occurred: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Place of incident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Description of Incident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Actions Taken:**

**\_\_\_\_\_\_**Sent to the nurse Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Recommendations:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**It is our intentions that parents/guardians be informed of their child’s behavior/incident/ and /or accident so that the school and home can work together to insure a safe and respectful educational environment. Please discuss this incident with your child.**

**Sincerely,**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PLEASE SIGN AND RETURN FORM TO SCHOOL BY THE NEXT SCHOOL DAY.**

**Parent acknowledgement**

**I have been informed of my child’s incident and or accident that happened during school.**

**Signature of Parent/Guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MERCEDES INDEPENDENT SCHOOL DISTRICT**

****

**MEDICAL SERVICES**

**950 W 6th St, Mercedes, TX 78570 |956-825-5075**

**NOTICE TO PARENT OF MEDICATION IN NURSE’S OFFICE NEEDING TO BE PICKED UP**

**Dear Parent of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Your child has a medication in the nurse’s office that needs to be picked up before the last day of school. In order to provide safety to your child, we are asking that you pick up the medication before \_\_\_\_\_\_\_\_\_\_\_\_\_\_. Medication that is in nurse’s office: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. Any medication that is not picked up by the last day of school will be discarded properly by the school nurse. If you have any questions, please call the school nurse to 956-\_\_\_\_\_\_\_\_\_\_\_\_\_.

**Yes** \_\_\_\_\_ I will pick up my child’s medication before the last day of school.

**No** \_\_\_\_\_ I cannot pick up the medication. I consent to have the medication disposed of properly by the school nurse.

***Please sign form and return to the school nurse by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent signature Date

**AVISO A LOS PADRES SOBRE EL MEDICAMENTO EN LA ENFERMERIA**

**Estimado padre de** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Fecha**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Su hijo/a tiene medicamento en la oficina de la enfermera y es necesario que este sea recogido antes del último día escolar. Por la seguridad del alumno estamos pidiendo que el medicamento recogido para \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. El medicamento que se encuentra en la enfermera es\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. Cualquier medicamento que no sea recogido para el último día escolar será adecuadamente descartado para \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. Si tiene alguna pregunta favor de llamar a la enfermera al 956-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**Si\_\_\_\_\_** Levantare el medicamento de mi hijo/a antes del último día escolar.

**No\_\_\_\_** No podre levantar el medicamento. Autorizo que el medicamento sea adecuadamente descartado.

***Favor de firmar y regresar esta forma a la enfermera para el día \_\_\_\_\_\_\_\_de \_\_\_\_\_ del\_\_\_\_\_\_\_\_\_\_.***

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Firma del Padre/Guardián Fecha

**MERCEDES INDEPENDENT SCHOOL DISTRICT**

****

**MEDICAL SERVICES**

**950 W 6th St, Mercedes, TX 78570 |956-825-5075**

**NOTICE TO PARENT OF FORM(S) NEEDED FOR THE NEW SCHOOL YEAR**

**Parent or Guardian of** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, Room: \_\_\_\_\_\_\_\_\_\_

Attached is a medical form that will be needed for the new school year. Please take this form to your child’s doctor over the summer and return form back to the school nurse during registration or on the first day of school. Your child’s doctor may also fax the form to 956-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. Please note that all forms and doctor’s order are only valid for the current school year. A new form will be required every new school year. If you have any questions, please call the school nurse to 956-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Thank you,

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School Nurse

**AVISO A LOS PADRES SOBRE LAS FORMAS NECESARIAS PARA EL SEGUNTE AÑO ESCOLAR**

**Estimado padre de** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

Adjunto está la forma médica que su hijo/a tiene con la enfermera de la escuela. Favor de llevar esta forma a su doctor durante el verano y regresarla el próximo año escolar cuando inscriba a su niño/a. El doctor de su niño/a puede mandarla por fax al teléfono 956-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. Tenga en cuenta que todas las formas e indicaciones del doctor solamente son válidas para el presente año escolar. Una forma nueva es requerida para cada año escolar. Si tiene alguna pregunta favor de llamar a la enfermera de la escuela al 956-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Gracias por su atención,

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Enfermera de la escuela

**MERCEDES INDEPENDENT SCHOOL DISTRICT**

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**MEDICAL SERVICES**

**950 W 6th St, Mercedes, TX 78570 |956-825-5075**

**NOTICE TO PARENT OF HEAD LICE**

Dear Parent(s) or Guardian(s),

As part of the Health Services offered at our schools, the nurse examined the children for lice and a case of head lice has been detected. On \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ your child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, was found to have head lice or nits.

Anyone can get head lice. Mainly through direct head-to-head contact but also from sharing hats, brushes and other personal items. Head lice are a problem in many communities and do not reflect poor hygiene or social status. Please do your part to prevent the spread of this communicable condition by checking your child(ren) daily for the next few weeks, and on a regular basis thereafter. Lice infestation is much easier to treat if caught early.

Please stop by the nurse’s office so the nurse may clear your child upon returning to school. Your child may return to school the day after the treatment is applied. If you should discover a case of head lice, please notify your child’s school.

If you have any questions, please contact the school nurse at **\_\_\_\_\_\_\_\_\_\_\_\_\_.**

Thank you for your cooperation,

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

School Nurse

**AVISO DE PIOJOS**

Estimado padre (s) o tutor (s),  
  
Como parte de los servicios de salud que se ofrecen en nuestras escuelas, la enfermera examinó a los niños para los piojos y se ha detectado un caso de piojos de la cabeza. En \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ su hijo \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, se encontró que tenía piojos o liendres.

Cualquier persona puede contraer piojos. Principalmente a través del contacto directo de cabeza a cabeza, sino también de compartir sombreros, cepillos y otros artículos personales. Los piojos son un problema en muchas comunidades y no reflejan la falta de higiene o condición social. Por favor haga su parte para evitar la propagación de esta enfermedad transmisible mediante la comprobación de su hijo (s) al día durante las próximas semanas, y de forma periódica a partir de entonces. Infestación de piojos es mucho más fácil de tratar si se detecta a tiempo.

Favor de pasar a la oficina de la enfermera para que ella de la aprobación de regreso a la escuela. Su hijo puede regresar a la escuela tan pronto como se aplica el tratamiento sea aplicado. Si usted descubre un caso de piojos, por favor notifique a la escuela de su hijo.

Si usted tiene alguna pregunta, por favor póngase en contacto con la enfermera de la escuela en **\_\_\_\_\_\_\_\_\_\_\_\_\_\_.**

Gracias por su cooperación,

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Enfermera De La Escuela

**MERCEDES INDEPENDENT SCHOOL DISTRICT**

****

**Medical Services**

**950 W 6th St, Mercedes, TX 78570 |956-825-5075**

**NOTIFICATION OF HEAD LICE IN THE CLASSROOM**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dear Parent or Guardian:**

This note serves as notification that a student in your child’s class has been identified to have lice. Senate Bill 1566 was passed during the Legislative session 2017 to require the school to notify parents of a classroom occurrence of lice. Head lice, although not an illness or a disease is very common among children and is spread through head-to-head contact during play, sports and when children share items like combs, hats, brushes, and headphones.

According to Mercedes ISD policy, a child diagnosed with live head lice will be sent home from school; be treated, and return to class after appropriate treatment has begun and cleared by school nurse. Nits may persist after treatment, but continued treatment and daily hair checks at home are necessary to eliminate the lice.

**Recommendations for parents:**

1. Check your child’s hair daily. If you find lice, treat your child and any children who share rooms or beds in the house. In addition, the sheets and clothes must be washed in hot water.  Stuffed animals or other items which cannot be washed should be bagged for 48 hours. Soak combs and brushes in hot water for 5-10 minutes. Retreat child in 7-9 days until no lice are seen to prevent reinfestation.
2. If no lice are found, you can use preventative sprays on your child to prevent he/she from head lice.
3. Follow treatment guidelines from the CDC, website available below.
4. For recurrent hair lice or lice resistance to the medication, please visit your child’s doctor for alternative treatment.

The Centers for Disease Control and Prevention can be utilized as a resource for treatment and prevention of lice. Treatment options can be found at <https://www.cdc.gov/parasites/lice/head/treatment.html> and prevention tips at <https://www.cdc.gov/parasites/lice/head/prevent.html>.

If you have any questions, feel free to contact the nurse’s office.

Sincerely,

School Nurse

**MERCEDES INDEPENDENT SCHOOL DISTRICT**

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**MEDICAL SERVICES**

**950 W 6th St, Mercedes, TX 78570 |956-825-5075**

**ANAPHYLAXIS INDIVIDUAL HEALTH PLAN**

Name of Student: Birthdate: Student I.D. #:

Allergy: Reaction:

INDICATION FOR USE OF ANTIHISTAMINE, STEROIDS, OR EPI-PEN/EPI-PEN JR.

1. After the use of an Epi-pen/Epi-pen Jr., call EMS/911 immediately for follow up
2. At onset of hives, itching or swelling, take an antihistamine:
   1. BENADRYL (25mg tab/syrup) \_\_\_\_\_\_\_\_\_\_ by mouth
   2. HYDROXYZINE (25mg tab/syrup) \_\_\_\_\_\_\_\_\_\_ by mouth

\*IF HIVES/ITCHING CONTINUE, INDIVIDUAL MAY TAKE BENADRYL/HYDROXYZINE EVERY 4-6 HOURS.

* Hives (appearing red, itchy bumps)
* Generalized itching especially of the palms of the hands soles of the feet, or the groin area
* Swelling of face or body part

1. At onset of severe rash or swelling take:
   1. Prednisone \_\_\_\_\_\_\_\_\_mg \_\_\_\_\_\_\_\_\_ tablets by mouth
   2. Prelone 15mg/5ml \_\_\_\_\_\_\_\_\_ teaspoonful by mouth
   3. Orapred ODT \_\_\_\_\_\_\_\_\_mg let dissolve on the tongue

\*CALL YOUR DOCTOR FOR FUTHER INSTRUCTIONS.

1. Use injectable epinephrine (Epi-pen/Epi-pen Jr.) and antihistamines if any of the following occur:
   1. Light-headedness or dizziness
   2. Palpitations
   3. Shortness of breath or chest tightness
   4. Hoarseness or tightness of the throat
   5. Abdominal cramping, nausea, vomiting, or diarrhea or difficulty swallowing, if associated with any of the above signs

NOTE: IF THE STUDENT EXPERIENCES ANY OF THE FOLLOWING SIGN OR SYMPTOMS NOTED BELOW, CALL EMS/911. IN ADDIITON TO THE STEPS OUTLINED BELOW, REMEMBER THAT LATE REACTIONS CAN OCCUR UPTO

8-12 HOURS AFTER AN INJECTION.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Treating Physician Printed Name Treating Physician Signature Telephone Number

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Telephone Number Date

**For School Nurse Use Only:**

Submitted to Nurses Office on:

\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_

MM / DD / YYYY

**MERCEDES INDEPENDENT SCHOOL DISTRICT**

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**SERVICIOS MEDICOS**

**950 W 6th St, Mercedes, TX 78570 |956-825-5075**

**PLAN INDIVIDUAL DE LA SALUD DE ANAPHYLAXIS**

Nombre del alumno: Fecha De Nacimiento: I.D. #:

Alergia: Reacción:

INDICACIÓN PARA EL USO DE ANTIHISTAMÍNICO, esteroides o EPI-PEN / EPI-PEN JR..

1. Después de que el uso de un Epi-pen / Epi-pen Jr., llame a EMS / 911 de inmediato para su seguimiento
2. Al inicio de la urticaria, picazón o hinchazón, tomar un antihistamínico:
   1. BENADRYL (25mg tab/syrup) \_\_\_\_\_\_\_\_\_\_ by mouth
   2. HYDROXYZINE (25mg tab/syrup) \_\_\_\_\_\_\_\_\_\_ by mouth

\* SI ERUPCIÓN CONTINUAR, INDIVIDUO PUEDE TOMAR BENADRYL O HYDOXYZINE CADA 4-6 HORAS.

* Erupción (aparecen ampollas rojas y comezón)
* Comezón generalizada especialmente en la palma de las manos, planta de los pies p el área privada de cuerpo
* Hinchazón de la cara o parte del cuerpo

1. Al darte comezón severa o hinchazón:
   1. Prednisone \_\_\_\_\_\_\_\_\_mg \_\_\_\_\_\_\_\_\_ tabletas vía oral
   2. Prelone 15mg/5ml \_\_\_\_\_\_\_\_\_ cucharadita vía oral
   3. Orapred ODT \_\_\_\_\_\_\_\_\_mg dejar disolver en la lengua

\*SI NECESITAS MAS INSTRUCIONES, LLAMA A TU DOCTOR.

1. Usa epinephrine inyectable (Epi-pen/Epi-pen Jr.) y antihistamínicos si sientes alguno de los siguientes síntomas:
2. Mareos
3. Palpitaciones
4. Falta de replicación o pecho comprimido
5. Afonía voz ronca o granita oprimida
6. Dolor abdominal, nausea, vomito a diarrea, o dificultad para ingerir alimentos, si está asociado con cualquiera de los síntomas anteriores.

NOTA: SI EL ESTUDIANTE EXPERIENCIAS DE CUALQUIER SIGNO SIGUIENTE O SÍNTOMAS SENALA MAS ADELANTE, LLAME EMS/911. CONTINUA LOS PASOS DESCRITOS, RECUERDE QUE REACCIONES TARDIAS PUEDEN OCURRIR HASTA 8-12 HORAS DESPUES DE UNA INYECCION.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tratamiento Médico Nombre Impreso Firma del Médico Número de Teléfono

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contacto De Emergencia Número de Teléfono Fecha

**For School Nurse Use Only:**

Submitted to Nurses Office on:

\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_

MM / DD / YYYY

**MERCEDES INDEPENDENT SCHOOL DISTRICT**

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**SERVICIOS MEDICOS**

**950 W 6th St, Mercedes, TX 78570 |956-825-5075**

**ASTHMA ACTION PLAN**

**SCHOOL YEAR: \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ CAMPUS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FAX #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Grade: \_\_\_\_\_\_\_\_\_\_\_ Parent/Guardian Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*(*Circle one*)** Patient ***MAY/MAY NOT*** be allowed to carry and self-administer rescue inhaler in school/at school-related events.

|  |
| --- |
| **\*(*Check****)* **DIAGNOSIS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Severity** (*Select one*): Intermittent Exercise Induced Asthma/Bronchoconstriction  **Persistent**: Mild; Moderate;Severe  **RESCUE MEDICATION:**Proventil HFA; Ventolin HFA; Xopenex HFA; ProAir HFA; ProAir RespiClick; Nebulizer  **NEEDS INHALER BEFORE EXERCISE**:  YES NO; GIVE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_MINUTES BEFORE EXERCISE  AS NEEDED  **PREVENTATIVE MEDICATION (*taken at home*):** \_\_\_\_\_\_\_\_\_ Inhaler Diskus  #\_\_\_\_\_\_Inhalations/Puffs \_\_\_\_\_times a day; Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **What triggers my asthma:**Smoke Mold Tree/Grass/Weed/Pollen Cold/Virus Exercise Weather Other:\_\_\_\_\_\_\_\_ |

|  |  |  |
| --- | --- | --- |
| **GREEN ZONE:** DOING WELL | **YELLOW ZONE:** ASTHMA GETTING WORSE | **RED ZONE:** MEDICAL ALERT |
| If no cough, wheeze, chest tightness or shortness of breath during the day/night and can do usual activities, ***then***:  **Take as Needed *before* exercise**:  2 puffs of Rescue Medication 5-15 mins before exercise  Macintosh HD:Users:marcusnarro:.Trash:healthy.jpg | **If** cough, wheeze, chest tightness or shortness of breath; waking at night due to asthma; or can do some but not all usual activities, ***then***:  **TAKE** rescue inhaler dose 2-4 puffs every 20 mins for up to 1 hour as needed for cough, wheeze, shortn­­ess of breath or chest tightness.  ***or:***  *Nebulizer*, once or up to every 20 mins for up to 1 hour for cough, wheeze, shortness of breath or chest tightness.  ***Call the healthcare Provider within 24 hours if asthma symptoms do not improve***  **IF AT SCHOOL:**  Return student to classroom if stable & symptoms return to green zone *and* continue monitoring to be sure student remains in GREEN ZONE  Or if symptoms do not return to GREEN ZONE after 1 hour of treatment:  **TAKE**: Rescue Inhaler 2-4 puffs and  ***CALL*** parent and health care provider. | ***IF ONE OR MORE OF THE FOLLOWING ARE PRESENT:***   * Coughing, wheezing, shortness of breath, not helped with medications * Hard time breathing with chest and neck pulled in with breathing: Child is hunched over * Trouble walking or talking due to shortness of breath * Stops playing and cannot start activity again * Lips or fingernails are grey or blue ***then***:   **Macintosh HD:Users:marcusnarro:.Trash:sick.pngMacintosh HD:Users:marcusnarro:Desktop:2000px-Blue_asthma_inhaler_graphic.svg.pngTAKE RESCUE INHALER 4-6 inhalations or nebulizer. Call 911, parent and healthcare provider. Repeat the dose if not improved in 15-20 mins.** |

***\*Parent:*** *By signing below, I give my child’s school permission to administer daily emergency medications as necessary in accordance with physician’s*

*instructions above. I authorize health information sharing on my child with relevant school officials and health care providers.*

**Parent/Guardian Signature Physicians Signature Date:**

x \_\_\_\_\_ x \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MERCEDES INDEPENDENT SCHOOL DISTRICT**

****

**MEDICAL SERVICES**

**950 W 6th St, Mercedes, TX 78570 |956-825-5075**

**SCHOOL ASTHMA ACTION PLAN**

This plan is in accordance with legislation, HB 1688, which was passed during the 2001 Texas Legislative Session. This bill allows students to self-administer asthma medications while at school or school functions with the permission from parents and physicians.

This plan is to be completed at the beginning of each year and kept on file with the school nurse or office of the principal.

Name of Student: DOB: Student I.D. #:

Teacher’s Name: Grade: School Year:

**Parent/Guardian Contact Information**

Name: Home Phone:

Address: Work Phone:

**Emergency Contact:**

Name: Relationship: Telephone:

Physician seen for asthma: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***SELF-ADMINISTRATION OF ASTHMA MEDICATIONS***

It is to my professional opinion that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (student’s name) should NOT be allowed to carry any of his/her asthma medication while on school property or at school-related events.

I have instructed, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (student’s name) in a proper way to use his/her medications. It is to my professional opinion that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (student’s name) should be allowed to carry and self-administer the following medications while on school property or at a school-related event.

**B. Other Medication**

Purpose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When to use: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Can be repeated for severe breathing difficulty \_\_\_\_\_\_\_\_\_\_\_\_ time’s \_\_\_\_\_\_\_\_\_\_\_min. apart

Additional Instructions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

These medications are proscribed for the time period \_\_\_\_\_\_\_\_\_\_\_\_ until \_\_\_\_\_\_\_\_\_\_\_\_.

**A. Bronchodilator (Quick-relief medication)**

Purpose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When to use: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Can be repeated for severe breathing difficulty \_\_\_\_\_\_\_\_\_\_\_\_ time’s \_\_\_\_\_\_\_\_\_\_\_\_min. apart

These medications are proscribed for the time period \_\_\_\_\_\_\_\_\_\_\_\_ until \_\_\_\_\_\_\_\_\_\_\_\_.

\*Call 911 or EMS if minimal or no improvement

Physicians Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PAGE 1 OF 2**

**DAILY TREATMENT PLAN**

Please list any medications taken daily to manage asthma, including nebulizer treatments.

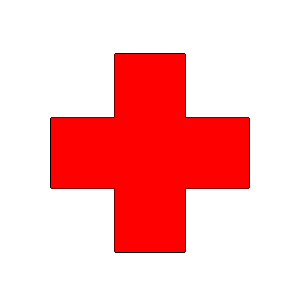
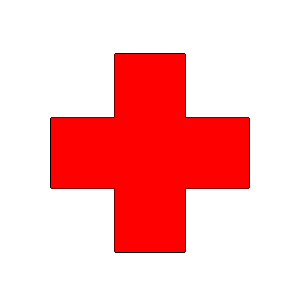
|  |  |  |  |
| --- | --- | --- | --- |
| **Name of Medication** | **Purpose of Medication** | **Dosage of Medication** | **When to use medication** |
| 1. |  |  |  |
| 2. |  |  |  |
| 3. |  |  |  |

These medications are proscribed for the time period of \_\_\_\_\_\_\_\_\_\_\_\_ until \_\_\_\_\_\_\_\_\_\_\_\_\_.

**MEDICAL EQUIPMENT**

Please list any medical equipment this student will need to treat his/her asthma at school (i.e. spacer, nebulizer, oxygen, etc.)

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| **EMERGENCY PLAN** |

Emergency action is necessary when this student has symptoms such as:

|  |
| --- |
|  |

Steps to take during an asthma episode:

1. Give emergency medications proscribed by physician:

**A. Bronchodilator (Quick-relief medication)**

Purpose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When to use: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Can be repeated for severe breathing difficulty \_\_\_\_\_\_\_\_\_\_times \_\_\_\_\_\_\_\_\_\_min. apart

These medications are proscribed for the time period \_\_\_\_\_\_\_\_\_\_\_\_ until \_\_\_\_\_\_\_\_\_\_\_\_.

**B. Other Medication**

Purpose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When to use: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Can be repeated for severe breathing difficulty \_\_\_\_\_\_\_\_\_\_times \_\_\_\_\_\_\_\_\_\_min. apart

Additional Instructions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

These medications are proscribed for the time period \_\_\_\_\_\_\_\_\_\_\_\_ until \_\_\_\_\_\_\_\_\_\_\_\_.

1. Seek emergency medical care if this student experiences any of the following:

* No improvement within 15-20 minutes after initial treatment with medication and a relative cannot be reached

Examples of this include:

|  |  |
| --- | --- |
| * Chest and neck pulled in while breathing * Hunched over while breathing * Struggling to breathe | * Trouble walking or talking * Stops playing and cannot start activity again * Lips or fingernails turn gray or blue |

**Comments and Special Instructions:**

|  |
| --- |
|  |

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**For School Nurse Use Only:**

Submitted to Nurses Office on:

\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_

MM / DD / YYYY

Physician’s Signature Date

By signing below, I give my child’s school permission to administer daily emergency medications as necessary.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent’s Signature Date

**PAGE 2 OF 2**

**MERCEDES INDEPENDENT SCHOOL DISTRICT**

****

**MEDICAL SERVICES**

**950 W 6th St, Mercedes, TX 78570 |956-825-5075**

**DIABETES MANAGEMENT AND TREATMENT PLAN**

***(Annual Health Service Prescription- Physician/Parent Authorization for Diabetic Care)***

This form is to be renewed at the beginning of every school year.

Name of Student: DOB: Date of Plan / /

|  |
| --- |
| **THIS SECTION IS TO BE COMPLETED BY PHYSICIAN** |
| Please respond to the following questions based on your records and knowledge of the student. |
| **1. PROCEDURES (parent is to provide supplies for procedures)** |
| Test blood glucose before lunch and as needed for signs/symptoms of hypoglycemia.  Test urine ketones when blood glucose is hyperglycemic, and or when child is ill. |
| **2. MEDICATIONS** |
| Child may \_\_\_\_\_\_\_\_\_ may not \_\_\_\_\_\_\_\_\_\_ prepare/administer insulin injection.  Rapid acting insulin [Regular/Humalog/Novolog] given subcutaneously prior to lunch time (within 30 min. prior to lunch) based on the following guidelines:   1. Fixed dose: \_\_\_\_\_\_\_\_\_\_\_\_ units plus insulin correction scale; OR 2. Insulin to Carbohydrates Ratio: 1 unit of insulin per \_\_\_\_\_\_\_\_\_grams carbohydrate plus insulin correction scale   INSULIN CORRECTION SCALE:  Blood Glucose below \_\_\_\_\_\_\_\_\_\_\_\_= no additional insulin  Blood Glucose from \_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_ unit(s) insulin subcutaneously  Blood Glucose from \_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_ unit(s) insulin subcutaneously  Blood Glucose over \_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_ unit(s) insulin subcutaneously  (Please notify parent if blood glucose is over \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)   1. Oral diabetes medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2. Student is to eat lunch following pre-lunch blood test and required medication 3. Parent/family instructed in diabetes self-management   Parent may \_\_\_\_\_\_\_\_ may not\_\_\_\_\_\_\_\_\_\_ adjust pre-lunch insulin dosage by up to 10% every 4 to 5 days as indicated by glucose trends, *parent will communicate changes to school health services personnel* |
| **3. PRECAUTIONS** |
| Refer to the physician’s orders for Guidelines for Responding to Blood Glucose Test Results on the following page.   1. Hypoglycemia: Signs of hypoglycemia include trembling, sweating, shaking, pale, weak, dizzy, sleepy, lethargic, confusion, coma, or seizures 2. Hyperglycemia: Signs include frequency of urination, excessive thirst and positive urinary ketones. |
| **4. MEAL PLAN** |
| The consent carbohydrate diet emphasizes consistency in the number of grams of carbohydrate eaten from day to day at each meal or snack. Proteins and fats are “free foods” in that they have minimal effect on the blood glucose level. The child and parent can choose the carbohydrate product that they wish to use of meals and snacks. *Parent will communicate meal plan change to school personnel.*   |  |  | | --- | --- | | Breakfast \_\_\_\_\_\_\_\_\_\_\_grams at \_\_\_\_\_\_\_\_\_\_\_\_ time  Lunch \_\_\_\_\_\_\_\_\_\_\_grams at \_\_\_\_\_\_\_\_\_\_\_\_ time | Mid A.M. snack \_\_\_\_\_\_\_\_\_\_\_\_grams at \_\_\_\_\_\_\_\_\_\_\_\_\_\_ time  Mid P.M. snack \_\_\_\_\_\_\_\_\_\_\_\_grams at \_\_\_\_\_\_\_\_\_\_\_\_\_\_ time |   The Insulin of Carbohydrate Ratio Meal Plan allows a variable amount of carbohydrate to be eaten at any meal or snack, but requires appropriate insulin to balance the carbohydrate. The ratio is listed above at 2-b.  Does this student have an insulin pump? Yes \_\_\_\_\_ No \_\_\_\_\_ (If yes, please attach student’s pump guidelines) |

**PAGE 1 OF 2**

**PHYSICIAN’S PORTION CONTINUED ON THIS PAGE.**

|  |
| --- |
| **THIS SECTION IS TO BE COMPLETED FOR DIABETIC SELF-CARE ONLY** |
| Does this student have permission to provide self-care? (Please check one)  Yes \_\_\_\_\_\_ No \_\_\_\_\_\_\_  Has this student been provided instruction/supervision in recognizing signs/symptoms of hypoglycemia and is capable of doing self-glucose monitoring and his/her own insulin injections/insulin pump care, including using universal precautions and proper disposal of sharps? (Please check one)  Yes \_\_\_\_\_\_ No \_\_\_\_\_\_\_  Please check the answer best to your knowledge below:  This student requires the SUPERVISION of a designated adult \_\_\_\_\_\_\_ OR This student requires the ASSISTANCE of a designated adult \_\_\_\_\_\_\_ |
| **GUIDELINES FOR RESPONDING TO BLOOD GLUCOSE TEST RESULTS** |
| 1. If glucose is BELOW \_\_\_\_\_\_\_\_\_\_\_\_: (hypoglycemia or low blood sugar)   1. Give student 15 grams of a carbohydrate (Example: 6 lifesavers, 4 oz. of juice, 6 oz. of regular soda, 3-4 glucose tabs) 2. Allow child to rest for 10-15 minutes, and retest glucose 3. If Glucose is above \_\_\_\_\_\_\_\_\_\_\_, allow the student to proceed with scheduled meal, class or snack. 4. If symptoms persist (or blood glucose remains below \_\_\_\_\_\_\_\_\_\_), repeat A & B 5. If symptoms still persist, notify parent and keep child in clinic   2. If blood glucose is BELOW \_\_\_\_\_\_\_\_\_\_\_\_ and the child is unconscious or seizing:   1. Call emergency medical services such as EMS(956-720-4862) or 911 2. Rub a small amount of glucose gel (or cake frosting) on child’s gums and oral mucosa 3. If available, inject Glucagon \_\_\_\_\_\_\_\_\_\_\_mg SQ. 4. Notify parent(s) or guardian(s)   3. If blood glucose is FROM \_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_:   1. Follow usual meal plan and activities (unless otherwise directed by insulin correction scale for insulin administration)   4. If blood glucose is OVER \_\_\_\_\_\_\_\_\_\_\_:   1. If within 30 minutes prior to lunch, school nurse or unlicensed diabetes care assistant to be called if student is unable to administer correction dose of insulin per student’s sliding scare orders. 2. Student checks urine ketones   **If ketones are negative or small**   * + - Encourage water until ketones are negative   **If ketones are moderate or large**   * + - Student should remain in nurses office for monitoring     - Notify parent(s) or guardian(s) for pick up     - Give 1-2 glasses of water every hour     - If student remains at school, retest glucose and ketones every 2-3 hours or until ketones are negative  1. Student is not to participate in PE or other forms of exercise of blood sugar is above 250 and ketones are present. 2. If student develops nausea/vomiting, rapid breathing, and/or fruity odor to the breath call 911, school nurse, and the parent(s) or guardian(s). |

Physician’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinic/Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nurse of Certified Diabetes Educator Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinical Dietician Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TO BE COMPLETED BY THE PARENT:**

I the undersigned parent/guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ request that the above Diabetes Management and Treatment Plan be implemented for my child. Delivery of this form to the school nurse constitutes my participation in developing this plan and is my consent to implement this plan. I will notify the school immediately if the health status of my child changes, including changing physicians, procedure cancellations, etc. Information concerning my child’s diabetes health management may be shared with and/obtained from the diabetes health care providers. I understand and give consent to the UDCA, when the school nurse is not available, to care for my child as stated on this plan.

Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**For School Nurse Use Only:**

Submitted to Nurses Office on:

\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_

MM / DD / YYYY

Home/Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PAGE 2 OF 2**

**MERCEDES INDEPENDENT SCHOOL DISTRICT**

****

**MEDICAL SERVICES**

**950 W 6th St, Mercedes, TX 78570 |956-825-5075**

**Monthly Blood Sugar Log**

**Student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Student I.D.#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **DATE** | **LUNCH**  **B/S** | **ACTION**  **TAKE** | **RECHECK TIME** | **RECHECK RESULTS** | **KETONES**  **NEG/POS** | **PRN**  **B/S TIME** | **ACTION TAKEN/ ADDITIONAL COMMENTS** | **INITIALS** | **VERIFY INSULIN INITIALS** |
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**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Campus Nurse**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_**

**Initials Initials**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_**

**Initials Initials**

**MERCEDES INDEPENDENT SCHOOL DISTRICT**

****

**MEDICAL SERVICES**

**950 W 6th St, Mercedes, TX 78570|956-825-5075**

**FOR STUDENTS WITH DIABETES-LOW BLOOD GLUCOSE (HYPOGLYCEMIA)**

**QUICK REFERENCE EMERGENCY PLAN**

(NEVER SEND OR LEAVE A STUDENT WITH SUSPECTED LOW BLOOD SUGAR ANYWHERE ALONE)

Student’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_\_\_\_\_\_\_ Date of Plan: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Teacher: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Room Number: \_\_\_\_\_\_\_ Pick Up\_\_\_\_\_ Walker \_\_\_\_\_\_ Bus #: \_\_\_\_\_\_

School Nurse: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ School Nurse Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Trained Diabetes Personnel: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is student self-care? (please check one) Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_

**EMERGENCY CONTACT INFORMATION:**

**Name of Emergency Contact #1:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name of Emergency Contact #2:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(THIS INFORMATION IS CONFIDENTIAL AND CAN ONLY BE PROVIDED TO APPROPRIATE SCHOOL STAFF)

**SEVERE**

|  |
| --- |
| * Call 911/EMS (956-720-4862) * Give Glucagon, only if ordered * Position on side * Contact parent or legal guardian, School Nurse, and school |

**MILD/MODERATE**

|  |  |
| --- | --- |
| * Provide Sugar/Glucose Source   15 gm glucose tablets or 4-8 oz. juice or regular soda or Glucose Gel   * Wait 10 minutes * Repeat sugar source if symptoms persist or blood glucose less than 70 | * Provide a snack of carbohydrate & protein, i.e. crackers and cheese * If student is a self-care, allow student to check blood sugar and eat a quick sugar source, if necessary * Communicate/notify parent or legal guardian, school nurse, and school |

**SEVERE**

|  |
| --- |
| * Unable to swallow * Combative * Unconscious * Seizure |

**MODERATE**

|  |
| --- |
| * Sleepiness * Erratic behavior * Poor coordination * Confusion * Slurred speech |

**MILD**

|  |  |
| --- | --- |
| * Hunger * Shakiness * Weakness * Anxiety * Irritable * Sweating | * Drowsiness * Unable to concentrate * Headache * Numbness of lip & tongue |

**ONSET**

* Sudden

**CAUSES OF HYPOGLYCEMIA**

* Too much insulin
* Missed food
* Delayed food
* Too much exercise/Unscheduled Exercise

**Please circle student’s usual symptoms below:**

**MERCEDES INDEPENDENT SCHOOL DISTRICT**

****

**MEDICAL SERVICES**

**950 W 6th St, Mercedes, TX 78570 |956-825-5075**

**FOR STUDENTS WITH DIABETES-HIGH BLOOD GLUCOSE (HYPERGLYCEMIA)**

**QUICK REFERENCE EMERGENCY PLAN**

(NEVER SEND OR LEAVE A STUDENT WITH SUSPECTED HIGH BLOOD SUGAR ANYWHERE ALONE)

Student’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_\_\_\_\_\_\_ Date of Plan: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Teacher: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Room Number: \_\_\_\_\_\_\_ Pick Up\_\_\_\_\_ Walker \_\_\_\_\_\_ Bus #: \_\_\_\_\_\_

School Nurse: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ School Nurse Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Trained Diabetes Personnel: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is student self-care? (please check one) Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_

**EMERGENCY CONTACT INFORMATION:**

**Name of Emergency Contact #1:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name of Emergency Contact #2:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(THIS INFORMATION IS CONFIDENTIAL AND CAN ONLY BE PROVIDED TO APPROPRIATE SCHOOL STAFF)

**ONSET**

* Over time-several hours or days

**CAUSES OF HYPERGLYCEMIA**

* Too much food
* Too little insulin
* Decreased activity
* Illness/Stress
* Infection

**Please circle student’s usual symptoms below:**

**SYMPTOMS PROGRESSIVELY**

**BECOME WORSE**

|  |  |
| --- | --- |
| * Sweet Breath * Weight loss * Facial flushing * Dry, warm skin * Vomiting | * Nausea/ stomach pains * Weakness * Confusion * Rapid breathing * Unconsciousness/coma |

**EARLY SYMPTOMS**

|  |
| --- |
| * Thirst/dry mouth * Frequent urination * Fatigue/ Sleepiness * Increased Hunger * Blurred visions * Lack of concentration |

**Check blood glucose (per ISHP):**

**FOR VOMITING WITH CONFUSION, LABORED BREATHING AND OR COMA**

|  |
| --- |
| * Call 911/EMS (956-720-4862) * Contact School Nurse * Contact parent or legal guardian |

**IF STUDENT IS NOT FEELING WELL**

|  |
| --- |
| * Call parents to pick up student * Provide water if student is thirsty * Provide additional treatment per ISHP (ketone, check insulin) * Notify school nurse if there are further immediate concerns or questions. |

**IF STUDENT IS FEELING OK**

|  |
| --- |
| * Provide water if student is thirsty * Provide additional treatment per ISHP * May resume classroom activities * Document action and provide a copy for the school nurse |

**MERCEDES INDEPENDENT SCHOOL DISTRICT**

****

**MEDICAL SERVICES**

**950 W 6th St, Mercedes, TX 78570 |956-825-5075**

**SEIZURE ACTION PLAN**

Student’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Teacher: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Room Number: \_\_\_\_\_\_\_ Pick Up\_\_\_\_\_ Walker \_\_\_\_\_\_ Bus #: \_\_\_\_\_\_

Physician Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY CONTACT INFORMATION:**

**Name of Emergency Contact #1:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name of Emergency Contact #2:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of seizure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What does the seizure look like and how long does it usually last? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Possible triggers that should be avoided? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does student need any special activity adaptions/protective equipment (e.g., helmet) at school? Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_

(Please explain below)

|  |
| --- |
|  |

Is the student allowed to participate in physical education and other activities? Yes \_\_\_\_\_\_ No \_\_\_\_\_\_

(Please explain below)

|  |
| --- |
|  |

Are medications needed to control seizures? (If yes, please list medications needed below) Yes \_\_\_\_\_\_ No \_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| **Medications** | **Dosage** | **How Often and for what signs** |
| 1. |  |  |
| 2. |  |  |
| 3. |  |  |
| **LIST MEDICATIONS NEEDED AT SCHOOL** | | |
| **Medication** | **Dosage** | **Frequency** |
| 1. |  |  |
| 2. |  |  |
| 3. |  |  |

Possible side effects that must be reported to parent or physician:

|  |
| --- |
|  |

**PAGE 1 OF 4**

|  |
| --- |
| **IF GENERALIZED SEIZURE OCCURS:** |
| 1. If falling, assist student to floor, turn to side 2. Loosen clothing at neck and waist, protect head from injury 3. Clear away furniture and other objects from area 4. Have another classroom adult direct the other students away from area 5. Time the seizure 6. Allow seizure to run its course, DO NOT restrain or insert anything into student’s mouth. Do not try to stop purposeless behavior 7. During a general or grand mal seizure expect to see pale or bluish discoloration of the skin or lips. Expect to hear noisy breathing |
| **IF SMALLER SEIZURE OCCURS:** |
| Examples of smaller seizures include: lip smacking, behavior outburst, staring, twitching of mouth or hands   1. Assist student to comfortable, sitting position. 2. Time the seizure 3. Stay with student, speak gently, and help student get back on task following seizure |
| **INTERVENTION** |
| 1. Call 911/ EMS (956-720-4862) 2. Start CPR for absent breathing or pulse |
| **WHEN SEIZURE COMPLETED** |
| 1. Reorient and assure student    1. Assist change into clean clothing if necessary    2. Allow student to sleep, as desired once fully alert and oriented    3. Allow student to eat, as desired, once fully alert and oriented 2. A student recovering from a generalized seizure may manifest abnormal behavior such as incoherent speech, extreme restlessness, and confusion, this may last from five minutes to hours 3. Inform parent immediately of seizure via telephone conversation if :    1. Seizure is different from usual type or frequency or has not occurred at school in past    2. Seizure meets criteria for 911/EMS emergency call    3. Student has not returned to “normal self” after 30-60 minutes 4. Record seizure on Seizure Activity Log |

**IF YOU WOULD LIKE ADDITIONAL CARE GIVEN, PLEASE DESCRIBE ACTION HERE:**

|  |  |  |  |
| --- | --- | --- | --- |
| **If Symptoms are:** | |  | |
| **Give:** |  | | |
| **Possible Side effects:** | | |  |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Treating Physician Printed Name Treating Physician Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone Number Date

**PARENT ACKNOWLEDGEMENT:**

I want this plan implemented for my child, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (student’s name) in school. I hereby give my permission for exchange of confidential information contained in the record of my child between the nurse and physician and my signature is an informed consent to share this medical information with school staff as a need to know for academic success and emergency plan as determined by the nurse.

Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approved by School Nurse

**For School Nurse Use Only:**

Submitted to Nurses Office on:

\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_

MM / DD / YYYY

School Nurse Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PAGE 2 OF 4**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **SEIZURE OBSERVATION RECORD** | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| Name of Student: |  | | | |  | I.D.#: |  | |  | Baseline weight: | | lbs. | |
|  | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| **DATE**  **(MM/DD/YYYY)** | |  | |  | | |  |  | | |  | |
| **PRESEIZURE OBSERVATION**  Note: activity, behaviors, triggering events | |  | |  | | |  |  | | |  | |
| **SEIZURE OBSERVATION** | | | | | | | | | | | | |
| Start Time | | | a.m.  p.m. | a.m.  p.m. | | | a.m.  p.m. | a.m.  p.m. | | | a.m.  p.m. | |
| End Time | | | a.m.  p.m. | a.m.  p.m. | | | a.m.  p.m. | a.m.  p.m. | | | a.m.  p.m. | |
| Conscious | | | Yes/No | Yes/No | | | Yes/No | Yes/No | | | Yes/No | |
| Facial movements  (twitching, chewing, smacking lips) | | |  |  | | |  |  | | |  | |
| Head movements  to the left or right | | |  |  | | |  |  | | |  | |
| Fell | | |  |  | | |  |  | | |  | |
| Incontinent  Urine, bowel movement | | |  |  | | |  |  | | |  | |
| Eye movements  To the left or right, up/down, blank stare, rolled back, rapid blinking, closed | | |  |  | | |  |  | | |  | |
| Verbal Sounds  Describe: gagging, throat clearing, drooling | | |  |  | | |  |  | | |  | |
| Breathing Changes  Noisy, slowing, or other | | |  |  | | |  |  | | |  | |
| Extremity Movement  Right arm and/or leg, left arm and/or leg, stiffening, jerking, limp, clenching | | |  |  | | |  |  | | |  | |
| Skin Color  Normal, red, pale, blue, (facial, lips, nails) | | |  |  | | |  |  | | |  | |
| **POST SEIZURE OBSERVATIONS** | | | | | | | | | | | | |
| Confused | | |  |  | | |  |  | | |  | |
| Sleepy, tired | | |  |  | | |  |  | | |  | |
| Alert | | |  |  | | |  |  | | |  | |
| Headache | | |  |  | | |  |  | | |  | |
| Speech Slurring | | |  |  | | |  |  | | |  | |
| Other | | |  |  | | |  |  | | |  | |
| Length of time for reorientation, wakefulness | | |  |  | | |  |  | | |  | |
| ADDITIONAL COMMENTS | | |  |  | | |  |  | | |  | |
| Parents notified  (Note Time) | | | YES/NO  Call Time:  Arrival Time: | YES/NO  Call Time:  Arrival Time: | | | YES/NO  Call Time:  Arrival Time: | YES/NO  Call Time:  Arrival Time: | | | YES/NO  Call Time:  Arrival Time: | |
| EMS/MERT activated, note time of call, time of arrival | | | Call Time:  Arrival Time: | Call Time:  Arrival Time: | | | Call Time:  Arrival Time: | Call Time:  Arrival Time: | | | Call Time:  Arrival Time: | |
| Staff Initials | | |  |  | | |  |  | | |  | |

**PAGE 3 OF 4**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **SEIZURE RECORD** | | | | | | | |
|  | | | | | | | |
| Name of Student: |  |  | I.D.#: |  |  | School: |  |
|  | | | | | | | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Date** | **Time Started** | **Behavior Before Seizure/Aura** | **First Body Part Involved** | **Total Body Parts Involved** | **Time Ended** | **Recovery Time** | **Recovery Behaviors** |
|  | a.m.  p.m. |  |  |  | a.m.  p.m. |  |  |
|  | a.m.  p.m. |  |  |  | a.m.  p.m. |  |  |
|  | a.m.  p.m. |  |  |  | a.m.  p.m. |  |  |
|  | a.m.  p.m. |  |  |  | a.m.  p.m. |  |  |
|  | a.m.  p.m. |  |  |  | a.m.  p.m. |  |  |
|  | a.m.  p.m. |  |  |  | a.m.  p.m. |  |  |
|  | a.m.  p.m. |  |  |  | a.m.  p.m. |  |  |
|  | a.m.  p.m. |  |  |  | a.m.  p.m. |  |  |
|  | a.m.  p.m. |  |  |  | a.m.  p.m. |  |  |
|  | a.m.  p.m. |  |  |  | a.m.  p.m. |  |  |
|  | a.m.  p.m. |  |  |  | a.m.  p.m. |  |  |
|  | a.m.  p.m. |  |  |  | a.m.  p.m. |  |  |
|  | a.m.  p.m. |  |  |  | a.m.  p.m. |  |  |
|  | a.m.  p.m. |  |  |  | a.m.  p.m. |  |  |
|  | a.m.  p.m. |  |  |  | a.m.  p.m. |  |  |

**PAGE 4 OF 4**

|  |  |
| --- | --- |
|  | **Seizure Observation Record** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Student Name: | | | | |
| Date & Time | |  |  |  |
| Seizure Length | |  |  |  |
| Pre-Seizure Observation (Briefly list behaviors, triggering events, activities) | |  |  |  |
| Conscious (yes/no/altered) | |  |  |  |
| Injuries (briefly describe) | |  |  |  |
| Muscle Tone/Body  Movements | Rigid/clenching |  |  |  |
| Limp |  |  |  |
| Fell down |  |  |  |
| Rocking |  |  |  |
| Wandering around |  |  |  |
| Whole body jerking |  |  |  |
| Extremity  Movements | (R) arm jerking |  |  |  |
| (L) arm jerking |  |  |  |
| (R) leg jerking |  |  |  |
| (L) leg jerking |  |  |  |
| Random Movement |  |  |  |
| Color | Bluish |  |  |  |
| Pale |  |  |  |
| Flushed |  |  |  |
| Eyes | Pupils dilated |  |  |  |
| Turned (R or L) |  |  |  |
| Rolled up |  |  |  |
| Staring or blinking (clarify) |  |  |  |
| Closed |  |  |  |
| Mouth | Salivating |  |  |  |
| Chewing |  |  |  |
| Lip smacking |  |  |  |
| Verbal Sounds (gagging, talking, throat clearing, etc.) | |  |  |  |
| Breathing (normal, labored, stopped, noisy, etc.) | |  |  |  |
| Incontinent (urine or feces) | |  |  |  |
| Post-Seizure  Observation | Confused |  |  |  |
| Sleepy/tired |  |  |  |
| Headache |  |  |  |
| Speech slurring |  |  |  |
| Other |  |  |  |
| Length to Orientation | |  |  |  |
| Parents Notified? (time of call) | | Call Time:  Arrival Time: | Call Time:  Arrival Time: | Call Time:  Arrival Time: |
| EMS Called? (call time & arrival time) | | Call Time:  Arrival Time: | Call Time:  Arrival Time: | Call Time:  Arrival Time: |
| Observer’s Name | |  |  |  |

*Please put additional notes on back as necessary*. Copyright 2008 Epilepsy Foundation of America, Inc

**MERCEDES INDEPENDENT SCHOOL DISTRICT**

****

**MEDICAL SERVICES**

**950 W 6th St, Mercedes, TX 78570, Texas|956-825-5075**

**PERMISSION FOR THE ADMINISTRATION OF SPECIALIZED HEALTH CARE PROCEDURE IN SCHOOL**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, the undersigned parent/guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

(Parent Name, please print) (Student name, please print)

Student’s Date of Birth: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

MM DD YYYY

Request that the following specialized health care procedure be administered to my child.

Specialized Health Care Procedure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that the designated person(s) will be performing the above mentioned health care procedure. It is to my understanding that the designated person(s) will use the procedure written into the student’s health care plan according to nursing standards and physician orders.

I will notify the school immediately if the health care status of my child changes, if we change physicians or the procedure is changed or cancelled. I understand that whenever possible, the specialized health care procedure should be provided before or after school hours.

Signature of Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PERMISO PARA LA ADMINISTACIÓN DE SALUD ESCOLAR**

Yo \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, el padre / guardián de \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,  
         (Nombre del Padre, por favor imprimir) (nombre del estudiante, en letra de imprenta)  
  
Fecha de Nacimiento del estudiante: \_\_\_\_\_\_ / \_\_\_\_\_\_ / \_\_\_\_\_\_  
                                           MM DD AAAA  
  
Solicitar que el siguiente procedimiento de atención médica especializada ser administrado a mi hijo.  
  
Especializada Procedimiento de Atención de la Salud: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
Entiendo que la persona (s) designada será la realización del procedimiento de atención médica antes mencionado. Es mi entendimiento de que la persona (s) designada utilizará el procedimiento escrito en el plan de atención de la salud del estudiante de acuerdo con las normas de enfermería y las órdenes del médico.  
  
Voy a notificar a la escuela inmediatamente si el estado de la atención de salud de mi hijo cambia, si cambiamos los médicos o el procedimiento se modifica o cancela. Entiendo que siempre que sea posible, el procedimiento especializado de atención médica debe ser proporcionado antes o después del horario escolar.  
  
Firma del padre / tutor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fecha: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
Dirección: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
Número Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Número de trabajo: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Número de la célula:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MERCEDES INDEPENDENT SCHOOL DISTRICT**

****

**MEDICAL SERVICES**

**950 W 6th St, Mercedes, TX 78570 |956-825-5075**

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Campus\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Campus Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mercedes, TX 78570

Phone: (956) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: (956) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Student’s Name: | | | | | | |  | | | | Date of Birth: | | |  | | | | | |
| Student’s address: | | | | | | | |  | | | Grade Level: | | |  | | | | | |
| I request and authorize | | | | | | | | | |  | | | | | | | | | to |
| release healthcare information of the student named above to: | | | | | | | | | | | | | | | | | | | |
|  | | Name: | | | |  | | | | | | | | | | | | | |
|  | | Address: | | | | | | |  | | | | | | | | | | |
|  | | City: | | |  | | | | | | | State: |  | | Zip Code: | | |  | |
| This request and authorization applies to: | | | | | | | | | | | | | | | | | | | |
| 🞎 Healthcare information relating to the following treatment, condition, or dates: | | | | | | | | | | | | | | | | |  | | |
|  |  | | | | | | | | | | | | | | | | | | |
| 🞎 All healthcare information | | | | | | | | | | | | | | | | | | | |
| 🞎 Other: | | |  | | | | | | | | | | | | | | | | |
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|  | | | |  | | | | | | | | | | | | | | | |
| Parent/Guardian Signature: | | | | | | | |  | | | | | Date Signed: | | |  | | | |
|  | | | | | | | | | | | | | | | | | | | |
| **THIS AUTHORIZATION EXPIRES AT THE END OF THE SCHOOL YEAR THAT IT IS SIGNED.** | | | | | | | | | | | | | | | | | | | |

**MERCEDES INDEPENDENT SCHOOL DISTRICT**

****

**MEDICAL SERVICES**

**950 W 6th St, Mercedes, TX 78570 |956-825-5075**

AUTORIZACIΌN PARA COMINICAR INFORMACIΌN MEDICA

Escuela\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dirección de la escuela\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mercedes, TX 78570

Teléfono: (956) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: (956) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Nombre del alumno: | | | | | |  | | | | Fecha de nacimiento: | | |  | | | | | |
| Dirección del estudiante: | | | | | | | |  | | Grado: | | |  | | | | | |
| Yo solicito y autorizo a | | | | | | | | |  | | | | | | | | | para |
| comunicar información médica del alumno mencionado anteriormente. | | | | | | | | | | | | | | | | | | |
|  | | Nombre: | | | |  | | | | | | | | | | | | |
|  | | Dirección: | | | | |  | | | | | | | | | | | |
|  | | Cuidad: | | |  | | | | | | Estado: |  | | Código Postal: | | |  | |
| Esta solicitud y autorización aplica para: | | | | | | | | | | | | | | | | | | |
| 🞎Comunicar información médica sobre algún tratamiento, condición o alguna fecha: | | | | | | | | | | | | | | | |  | | |
|  |  | | | | | | | | | | | | | | | | | |
| 🞎 Toda información medica | | | | | | | | | | | | | | | | | | |
| 🞎 Otro: | | |  | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
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|  | | | |  | | | | | | | | | | | | | | |
| Firma del padre/madre o guardián: | | | | | | | |  | | | | Fecha: | | |  | | | |
|  | | | | | | | | | | | | | | | | | | |
| **Esta autorización expira al final del año en cual es firmada.** | | | | | | | | | | | | | | | | | | |

**MERCEDES INDEPENDENT SCHOOL DISTRICT**

****

**MEDICAL SERVICES**

**950 W 6th St, Mercedes, TX 78570 |956-825-5075**

**MEDICATION ADMINISTRATION COMPETENCY**

**Campus Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ School year: \_\_\_\_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_**

I certify that I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have been instructed on the knowledge and skills required to administer medications to student(s). I have been trained by the school nurse with the Guide to Medication Administration in the School Setting and accept responsibility for performing medication administration accordance with each student’s plan of care when the school nurse is not available. I understand I need to maintain my skills yearly and as needed when new medications arise. I have been trained on how to safely administer medication with the right patient, right route, right medication, right time, right dose, right documentation, right diagnosis, and right response. I understand that the Principal of the school has the authority to assign this responsibility. I understand to seek assistance and guidance for any medications that are unfamiliar to me while performing this duty.

**Trainee signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I have assessed the Trainee’s skills to determine the success of the training I provided. Based on this assessment, it is reasonable and prudent for the Trainee to perform medication administration if I am not available. The trainee is deemed competent to perform this task when assigned by the campus Principal.

**Nurse’s signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MERCEDES INDEPENDENT SCHOOL DISTRICT**

****

**MEDICAL SERVICES**

**950 W 6th St, Mercedes, TX 78570 |956-825-5075**

**DOCUMENTING HISTORY OF VARICELLA ILLNESS (CHICKEN-POX)**

1. **“This is to verify that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_had Varicella disease**

**student’s name**

**(chicken-pox) on or about \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and does not need Varicella vaccine.”**

**date/age**

1. **By Seologic confirmation of Varicella immunity.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature Relationship to child Date**

**DOCUMENTACION DE ENFERMEDAD DE VARICELLA (VIRUELA)**

1. **“Esta forma es para verificar que \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_le ha pegado la viruela**

**nombre de estudiante**

**en \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_y no necesita la vacuna para viruela.**

**fecha/edad**

1. **O por confirmacion serologica de immunidad de la Varicella (viruela).**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Firma Relación con estudiante Fecha**

**MERCEDES INDEPENDENT SCHOOL DISTRICT**

****

**MEDICAL SERVICES**

**950 W 6th St, Mercedes, TX 78570 |956-825-5075**

**5TH GRADE GIRLS PUBERTY CONSENT FORM**

**Dear Parents:**

Our class is about to study an important lesson on the early stages of puberty, which many fifth graders are beginning to experience.

**The *Always Changing® Program* helps both boys and girls:**

• Understand the physical and emotional changes they experience during puberty and acknowledge these changes as a normal part of growth and development.

• Learn the physiology of their bodies and correct terminology for parts of the reproductive system.

• Understand that personal hygiene is each individual’s responsibility.

**In addition, the program helps girls:**

• Understand the menstrual cycle.

• Understand what to expect during a period.

• Learn how to manage periods while continuing with normal activities.

The *Always Changing Program****®***is based on national research and consultation with school nurses, health educators, parents and medical professionals. It has been a trusted resource for 25 years and has been taught to millions of students, nationwide. It is provided as a free educational service to our school by the P&G’s brands: Always® feminine protection products, Secret® deodorants and antiperspirants, Old Spice® body wash, deodorant and antiperspirants, and Head and Shoulders® hair care products.

We will begin the program on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. Please sign and return this letter by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_\_\_ indicating your permission for your child to participate in the lessons.

If you have any questions about the *Always Changing Program*®, or if you would like to review the program materials in advance, please call the school nurse, at\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. If you would like to view the videos, please go to www.pgschoolsprograms.com.

Thank you very much for your interest in this important education program.

*School Campus Nurse Date Sent*

***Parent: please fill out this section and send form back with child. Turn in form to school nurse.***

My child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, in room \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(Students Name) (Room #)*

\_\_\_\_\_\_\_ has my permission to participate in the *Always Changing 5th Grade Puberty Education Program*.

\_\_\_\_\_\_\_ does not have my permission to participate in the *Always Changing 5th grade Puberty Education Program*

x *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*(Parent’s Signature) (Date)*

**MERCEDES INDEPENDENT SCHOOL DISTRICT**

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**MEDICAL SERVICES**

**950 W 6th St, Mercedes, TX 78570 |956-825-5075**

**LETTER OF REFERRAL FOR A PROFESSIONAL VISION EXAMINATION**

Parents,

A vision exam was done by the Lion’s Club on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ as per your parental consent. Based on the results of the screenings we have conducted; you are advised to schedule a vision examination for your child and take the attached form with you. Please return the results of your child’s professional examination to the school nurse as soon as possible, since we are required to keep current vision examination results in your child’s health record. If you have any questions about the screening results or how to obtain further vision services please contact me to the phone number below.

Thank you,

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School nurse

(956)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EXAMEN PROFESIONAL DE LA VISTA**

Padres,

Un examen de la vista fue conducido por el club de Leones el \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ con el consentimento de los padres de cada niño. A base de los resultados de los exámenes que hemos hecho, esta es su notificación para que haga una cita, lo más pronto possible, con el oculista para más exámenes. Haga el favor de regresarnos los resultados de los exámenes profesionales de la vista de su niñola a la enfermera de la escuela, lo más pronto posible, ya que se nos requiere archivar los resultados actuales del examen. Si tiene alguna pregunta sobre los resultados o como obtener más servicios para un examen de la visión, puede comunicarse conmigo al teléfono que se encuentra al pie de la página.

Gracias,

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Enfermera de la escuela

(956)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **CONSENT FORM FOR VISION SCREENING**

Dear Parents or Guardian:

A free vision screening will be offered by the District 2-A3 Lions Club to your child on

at your child’s school.

The vision screening is done by the Spot PediaVision. The Spot has the ability to screen for vision and eye disorders in children beginning from 6 months of age. The Spot can screen your child's eye from just a few yards away and no physical contact is made with your child.

if your child's results indicate a possible vision problem, the preschool or daycare will be notified and a referral form will be sent home. *Please note that a referral does not mean that your child needs glasses or treatment; it does, however, mean that he/she should be checked by a professional.* We want your child to be healthy and get a good start in life. The sooner eye problems are discovered and treated, the better the outcome.

I, the undersigned, hereby give permission for my child to participate in the vision screening event.

**I understand the following:**

* There is no charge to participate in the vision screening process;
* I will be contacted with the results;
* The information obtained from this vision screening is to be considered a preliminary procedure only and does not constitute a diagnosis of vision problems;
* I understand that I am responsible for arranging for a full eye exam with an eye care professional if my child is referred as a result of the vision screening test;
* I understand that the Lions Club organization conducting the screening will not be held accountable for any errors of omission or misdiagnosis;
* This vision screening is not a substitute for a professional eye examination.

Signature of Parent or Guardian Printed Name Date

|  |
| --- |
| Please print:  Child's Name Age  Home/Cell Phone  PASS REFER |

* My child may be photographed for the Lions Kid Sight training, news articles, brochures, and web

page illustrations. Funded by: Lions District 2-A3 & Lions Club International Foundation



**FORMULARIO DE CONSENTIMIENTO PARA LA DETECCION DE VISION**

Estimados padres de familia a tutor:

Una evaluacion de vision gratuita sera ofrecida por el District 2-A3 Lions Club a su hijo o hija el \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_en la escuela de su hijo o hija.

La evaluacion de la vision se realiza mediante la Spot Pedia Vision. La Spot teine la capasidad para dectectar trastornos de la vision y el ojo en los ninos a partir de 6 meses de edad. La Spot puede filtrar el ojo de su hijo o hija de solo unos pocos metros de distancia y contacto fisico no se hace con sus niños.

Financiado por: Lions District 2-A3 & Lions Clubs International Foundation

Si los resultados de su hijo o hija indican un problema de vision, se notificara el preescolar o a la guarderia y una forma de referencia sera enviada a casa. Tenga en cuenta que una referencia no signif ca que su hijo o hija necesita anteojos/lentes o tratamientos, esto, sin embargo, significa que eUella debe ser evaluado por un profesional. Queremos que su hijo o hija sea saludable y obtener un buen cornienzo en la vida. Cuanto antes los problemas Oculares son descubiertos y tratados, major sera el reultado.

Yo el signatario, doy permiso para que nal hijo o hija participle en el evento de vision de deteccion. Entiendo lo siguiente:

* No hay ningun costo para participar en el proceso de la vision;
* Me contractaran con los resultados;
* La infoiaaacion obtenida de esta evaluacion de vision debe ser considerado un procedimiento preliminar solamente y no constituye un diagnostico de problemas de vision;
* Entiendo que soy responsable de organizer para un examen oftalmologico completo con una atencion profesional si mi hijo o hija es referido como resultado de la prueba de detection de vision;
* Entiendo quela organi7acion del Lions Club quien llevara a cabo la evaluacion no se hara responsable de ningun error de ornision o errores de diagnostico;
* Esta evivacion de la vision no es un sustituto de un examen ocular professional.
* Mi hijo o hija puede ser fotografiado para the Lions Kid Sight training, articulos de prensa, folletas y ilustraciones de la pagina web.

Firma del padre o tutor Nombre por escrito (impreso) Fecha

|  |
| --- |
| **Por favor imprimar:**  Nombre del nino Edad  Numbero de telefono en casa/celular  PASAR REFERIR |

**MERCEDES INDEPENDENT SCHOOL DISTRICT**

****

**MEDICAL SERVICES**

**950 W 6th St, Mercedes, TX 78570 |956-825-5075**

**HYPOGLYCEMIC EMERGENCY PLAN**

**Child’s Name:** **Date of Birth**:

**Grade**: **Room#:** **Teacher**:

**Date of Plan:** **School Year:**

**\*Target Blood Sugar for Child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_mg/dl**

**Emergency Contact Information**

Mother/Guardian:

Email address: Home phone:

Work phone: Cell:

Father/Guardian:

Email address: Home phone:

Work phone: Cell:

Health Care Provider:

Phone Number:

School Nurse:

Contact number(s):

Unlicensed Diabetes Care Assistant:

Contact number(s):

**\*Check Blood Sugar:** As needed \_\_\_\_\_\_\_\_\_\_\_\_ ACHS\_\_\_\_\_\_\_\_\_\_\_\_\_ other: \_\_\_\_\_\_\_\_\_\_\_\_\_

**\*(Circle one) It is my professional judgment that child MAY/MAY NOT check own blood sugar.**

**The child should never be left alone, or sent anywhere alone, or with another child, when experiencing hypoglycemia.**

|  |  |
| --- | --- |
| **Causes of Hypoglycemia** | **Onset of Hypoglycemia** |
| * Too much insulin * Missing or delaying meals or snacks * Not eating enough food (carbohydrates) * Getting extra, intense, or unplanned physical activity * Being ill, particularly with gastrointestinal illness | * Sudden-symptoms may progress rapidly |

**This is a double-sided form—highlighted sections on the back of the form must be completed**

|  |  |  |  |
| --- | --- | --- | --- |
| **Hypoglycemia Symptoms**  Circle child’s usual symptoms. | | | |
| **Mild to Moderate** | | | **Severe** |
| * Shaky or jittery * Sweaty * Hungry * Pale * Headache * Blurry vision * Sleepy * Dizzy * Confused * Disoriented | * Uncoordinated * Irritable or nervous * Argumentative * Combative * Changed personality * Changed behavior * Inability to concentrate * Weak * Lethargic * Other: | | * Inability to eat or drink * Unconscious * Unresponsive * Seizure activity or convulsions (jerking movements) |
| **Actions for Treating Hypoglycemia** | | | |
| Notify Program Nurse or Trained Diabetes Personnel as soon as you observe symptoms.  If possible, check blood glucose (sugar) at fingertip.  \*Treat for hypoglycemia if blood glucose level is less than\_\_\_\_\_\_\_\_\_\_\_ mg/dL.  WHEN IN DOUBT, ALWAYS TREAT FOR HYPOGLYCEMIA AS SPECIFIED BELOW. | | | |
| **Treatment for Mild to Moderate Hypoglycemia** | | **Treatment for Severe Hypoglycemia** | |
| * Provide quick-acting glucose (sugar) product equal to \_\_\_\_\_\_\_ grams of carbohydrates. Example of 15 grams of carbohydrates include: * 3 or 4 glucose tablets * 1 tube of glucose gel * 4 ounces of fruit juice (not low-calorie or reduced sugar) * 6 ounces of soda (1/2 can) (not low-calorie or reduced sugar) * Wait 10 to 15 minutes. * Recheck blood glucose level. * Repeat quick-acting glucose product if blood glucose level is less than \_\_\_\_\_\_\_\_\_ mg/dL. * Contact the child’s parents/guardian. | | * Position the child on his or her side. * Do not attempt to give anything by mouth. * Administer glucagon: \_\_\_\_\_\_\_ mg at thigh muscle site IM. * While treating, have another person call 911 (Emergency Medical Services). * Contact the child’s parents/guardian. * Stay with the child until Emergency Medical Services arrive. * Notify child’s health care provider. | |

Physician’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**By signing below, I give my child’s school permission to administer daily emergency medications as necessary as directed by the doctor above. I give consent to implement this plan for my child and will notify the school immediately of any health or medication changes for my child.**

**For School Nurse Use Only:**

Submitted to Nurses Office on:

\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_

MM / DD / YYYY

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent’s Signature Date

**MERCEDES INDEPENDENT SCHOOL DISTRICT**

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**MEDICAL SERVICES**

**950 W 6th St, Mercedes, TX 78570 |956-825-5075**

**MEDICATION INCIDENT REPORT**

*This form is to be completed whenever any one of the “Rights” of Medication Administration is not in place.*

Student’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Medication and Dose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Scheduled Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Route: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Prescribing Health Care Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Incident Occurred: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time Occurred: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Place: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person Administering Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Please describe the INCIDENT below. Always inform the school nurse and nurse supervisor of this situation. If the student was injured during the incident, further documentation and reporting will be required.*

**Describe the incident and how it occurred:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
|  | **Check Rights followed** | **Describe Action/Follow-Up Taken** |
| Right Student | Yes/No |  |
| Right Medication | Yes/No |  |
| Right Dose | Yes/No |  |
| Right Route | Yes/No |  |
| Right Time | Yes/No |  |

Outcome of child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Notified: Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_\_\_\_Nurse Notified: Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_\_\_\_

Administrator Notified: Date: \_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_\_\_\_Head Nurse Notified: Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Employee: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Administrator Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Submit form to Head Nurse**

**MERCEDES INDEPENDENT SCHOOL DISTRICT**

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**MEDICAL SERVICES**

**950 W 6th St, Mercedes, TX 78570 |956-825-5075**

**FIELD TRIP MEDICATION HANDOFF RECORD**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Destination: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Class/Grade: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Teacher: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Departure Time: \_\_\_\_\_\_\_\_\_\_\_\_ Return time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Nurse or designated medication trained staff**

I identified the child(ren) needing medication during the field trip described above. I prepared a copy of the medication log and authorization document and paired it with each original medication container.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Print Name Signature Date Time

|  |  |  |  |
| --- | --- | --- | --- |
| Student | Medication | Dosage | Time to be given |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
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|  |  |  |  |

**Field Trip Staff/Teacher**

I maintained the medications in a secure area at all times during the field trip. I documented the medications administered on the medication administration record. I reported any incidents to the nurse and completed appropriate documentation. I returned medications to the nurse or designated medication trained staff.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Print Name Signature Date Time

**MERCEDES INDEPENDENT SCHOOL DISTRICT**

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**MEDICAL SERVICES**

**P.O. Box 419|333 S. Ohio Mercedes, Texas|956-825-5075**

**MEDICATION ADMINISTRATION OR SPECIAL PROCEDURE RECORD**

School Year: \_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_

Student’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_\_\_\_\_\_\_ Teacher: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Room #: \_\_\_\_\_\_\_\_\_\_\_

Medication/Procedure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\***Time/initial** \***Inhaler Before PE**: Yes/No **Days of PE**:M T W TH F

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | **11** | **12** | **13** | **14** | **15** | **16** | **17** | **18** | **19** | **20** | **21** | **22** | **23** | **24** | **25** | **26** | **27** | **28** | **29** | **30** | **31** |
| **August** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **September** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **October** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **November** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **December** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **January** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **February** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **March** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **April** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **May** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **June** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **July** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

**X= NO SCHOOL A= ABSENT R= REFUSED MEDICATION/PROCEDURE O= OUT OF MEDICATION FT=FIELD TRIP NG=NOT GIVEN D/C=MEDICATION DISCONTINUED**

***School Nurse:*** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ **Start Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **End Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Initials**

***Principal:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ Initials Initials**

**Back of record**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_**

**Initials Initials**

**Date Medication Notes:**

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**Controlled Substance Log**

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| --- | --- | --- | --- | --- | --- | --- |
| **Date** | **Name of medication** | **Amount of pills or ml received by parent** | **Amount of pills or ml returned to parent** | **Nurse or Principal Signature** | **Parent Signature** | **Notes:** |
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***\*If medication has not been picked up by the last day of school, medication should be disposed of properly by the school nurse. Document below. \*Do not flush medications down the toilet or sink.\****

**Disposal of Medication**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Date** | **Medication** | **Amount (pill # or ml)** | **Location of disposal** | **Nurse’s Signature/Witness (for controlled medications)** |
|  |  |  |  |  |

**MERCEDES INDEPENDENT SCHOOL DISTRICT**

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**MEDICAL SERVICES**

**950 W 6th St, Mercedes, TX 78570**

**STATEMENT OF COMPETENCY FOR DIAZEPAM ADMINISTRATION**

**Student’s: Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_ Teacher**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Rm**: \_\_\_\_\_\_\_\_

**Campus Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I certify that I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have been instructed on the knowledge and skills required to administer Diazepam rectal medication for seizures. I have been trained to and accept responsibility for performing Diazepam rectal medication in accordance with each student’s Individualized Healthcare Plan when the school nurse is not available. I understand I need to maintain my skills and that the school nurse will regularly assess my performance to identify any needs for review or repetition of the training I have received to perform this/these skills. I have had the opportunity to ask questions and received satisfactory answers. I have been instructed on side effects, adverse effects, dosage, and proper disposal of the medication. I understand to seek assistance and guidance for any skills or tasks that are unfamiliar to me while performing this duty.

**Trainee signature**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have assessed the Trainee’s skills to determine the success of the training I provided. Based on this assessment, it is reasonable and prudent for the Trainee to perform Diazepam rectal medication administration if I am not available. This is in effect for the current school year \_\_\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_.

**Nurse’s signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PARENTAL AGREEMENT**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, the parent/guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby give permission for Diazepam rectal medication administration to care for my child in case of an emergency. I understand this person has been trained on this procedure and skill. I understand this person will be kept updated on any changes to medication regimen. I understand the trainee will not be held liable for any civil damages, as per Texas Health and Safety Codes.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent/Guardian Signature**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MERCEDES INDEPENDENT SCHOOL DISTRICT**

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**MEDICAL SERVICES**

**950 W 6th St, Mercedes, TX 78570**

**DISPOSAL OF MEDICATION RECORD**

**SCHOOL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SCHOOL YEAR: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Date** | **Child’s Name** | **Medication** | **Amount (pill # or ml)** | **Location of disposal** | **Signature/Witness** |
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**MERCEDES INDEPENDENT SCHOOL DISTRICT**

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**MEDICAL SERVICES**

**950 W 6th St, Mercedes, TX 78570**

**NURSES NOTES**

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| **Date and Time** |  |
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