HARRISON COUNTY SCHOOLS

OFFICE OF HEALTH SERVICES
445 W. Main Street
Clarksburg, WV 26301
(304) 326-7690
FAX (304) 326-7691

Dear Parent, Date_____

Please complete the enclosed forms and return them to your school nurse. This will serve as a guide for school personnel in direct contact with your child while in the school setting. If your child has emergency medication such as rescue inhaler, epipen or rescue seizure medication, these medications and forms must be delivered to school on or before the first day of school. It is very important everything is complete. Failure to comply with above requirements may result in your child not being able to begin the school year.

If you have any additional questions or concerns feel free to contact me at 304-326-_____. You may also refer to Harrison County Policy Guide or the county website www.harcoboe.com.

Sincerely,

Certified School Nurse

***If your child no longer requires a Health Care Plan for the following health condition, please sign below and return to school nurse.**

My child _____does not require medication or a care plan for (medical condition) _____. If there is any change in my student's medical condition or they will need to have medication at school, I will notify the school nurse immediately.

Parent Signature_____Date_____

***Please note if your student had an emergency medication (Epi Pen, Diastat, etc.) last school year that they no longer require, the school nurse will need an order from the medical provider stating the medication is no longer needed during the school day.**

Return To School Nurse

HARRISON COUNTY SCHOOL HEALTH SERVICES

EMERGENCY ACTION PLAN

ADD/ADHD

Student Name: _____ DOB: _____ Grade/Teacher: _____

EMERGENCY CONTACT INFORMATION

Parents/Guardians:	Phone #1:	Phone #2:	Phone #3:
Alternate Contact:	Phone #1	Phone #2:	Phone #3:

Meds student is taking at home_____

Student will be taking _____ at school and should report to the _____ daily at _____. ***(Medication)*** ***(Location)*** ***(Time)***

IF YOU SEE THIS:	DO THIS:
Loss of appetite, weight loss, persistent headache or stomachache, occasional motor tics & nervousness	***Notify school nurse for monitoring, as these are common side effects, especially when initiating new meds or changing doses.** ***Notify parent if persists or of great concern.**
Persistent and frequent motor or vocal tics: ***Motor- rapid repetitive muscle movements such as eye blinking, shoulder shrugging, head jerking, facial twitching or other movements** ***Vocal- sniffing, snorting, throat clearing, coughing, verbal outbursts, grunting, barking, repeating words or stuttering**	***Notify school nurse and/or parent immediately for follow up with physician.** ***Teacher may keep a log of occurrences of tics.**
Continued signs of inattention, impulsivity, and/or hyperactivity	***Report specific incidents/behaviors to parents and nurse.**

I understand and agree that per WVDE Medication Policy 2422.8:

1. I (or an adult delegate) must deliver all medication to the office and sign it in on the medication log.
2. Agree never to send the medication with my child.
3. Agree to supply refills in a prompt manner when notified, to avoid missed doses.

I understand and agree that information in this Emergency Action Plan will be shared with appropriate school staff.

_____ _____

Parent/Guardian Signature Date

School Nurse Received and Reviewed: _____ _____

School Nurse Signature Date

To Be Completed By School Nurse

Location of medicine_____ **Authorized person to give medicine**_____

Feb 2016 - Godenrod

School_____

Harrison County Schools Medication Form

Student Information

Student Name _____
Last First Middle

Birth Date _____ Homeroom Teacher _____ Grade _____

Medication Allergies_____

Physician

This section of the Medication Form is to be filled out by a licensed prescriber. Medication orders are valid for the current school year including any summer school programs or extended school year programs. A medication order is required for any prescription and non-prescription (over the counter) medication. If there is any change in medication, dosage, time, or route, a new medication order must be received before the medication can be administered by school personnel. By signing this form, the licensed prescriber is authorizing that this medication may be given at school.

(Use one form for each medication)

Medication _____ Diagnosis _____

Dose _____ Time _____ Route _____

Intended Effect of Medication _____

Potential Side Effects for this Medication _____

Other Medication(s) taken by student _____

If rectal Diastat/Diazepam or Klonopin is prescribed, may this be administered by unlicensed trained personnel? ___Yes ___No

Please note that Nasal Versed cannot be delegated to unlicensed personnel

May the student self-administer their emergency medication per county policy? ___Yes ___No

May the student carry their emergency medications on them per county policy? ___Yes ___No

Name and Title of Licensed Prescriber (**PRINT**) _____

Address _____

Phone _____ Fax_____

Signature of License Prescriber _____ Date _____

Parent/Guardian

Parent/Guardian Authorization

I understand the following:

- *Medication must be brought by an adult to the school in the original container and properly labeled with the child's name.
- *The licensed prescriber may be contacted concerning the medication order for reasons including, but not limited to clarification, effectiveness, administration time, dosage, discontinuation, or new medication order.
- *Medication administration and procedures may be delegated to school personnel who have been trained by and remain under direct or indirect supervision of the school nurse.
- *A photograph of my child may be taken to assist in the correct administration of my child's medication.
- *Information may be shared with appropriate school personnel to insure the safety of my student.
- *it is the parent/guardian responsibility to replenish long-term and emergency medications as needed and retrieve unused or expired medication from the school.
- *At no time will non-emergency medication be sent home with the student. It will be the responsibility of a parent/guardian to pick up all remaining medications from the school.

I hereby give permission for my child to receive medication at school per the Harrison County Schools Medication Policy and as ordered by my child's licensed prescriber. I have read and understand that Harrison County Board of Education and its employees are exempt from any liability, except for willful and wanton conduct.

Parent/Guardian Signature_____ Date_____

Form Received and Reviewed by School Nurse _____ Date _____
Signature