

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.**

**HARRISON COUNTY SCHOOL HEALTH SERVICES
EMERGENCY ACTION PLAN**

CYSTIC FIBROSIS

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

EMERGENCY CONTACT INFORMATION

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

MANAGEMENT	
Meals and Snack Time Management:	<p>* Student may have enzymes needed prior to food consumption. Student requires _____ enzymes prior to snack Student requires _____ enzymes prior to a meal <i>Attach completed Administration of Medication Form</i></p>
Airway Clearance Techniques:	<p>*Student has Chest Physical Therapy ordered? _____ <i>Attached Physician Order if needed</i></p> <p>*Aerosol Therapy-Student may require inhaler or nebulizer therapy during school day. Student has inhaler/nebulizer ordered at ___ am/pm <i>Attach completed Administration of Medication Form</i></p>
Physical Education Modification	<p>*Student may need increased fluids and increased salt intake during hot weather. <i>Attached Physician Order if needed</i></p>
IF YOU SEE THIS:	DO THIS:
<p><u>Symptoms of Airway Blockage</u> <i>Frequent or lingering cough, intermittent wheezing, difficulty exercising, excessive sputum production, difficulty breathing, repeated lung infections</i></p>	<p>*Please notify School Nurse *Notify parent/guardian</p>
<p><u>Symptoms of Salt Depletion</u> <i>Fatigue, weakness, vomiting, muscle cramps, abdominal pain, dehydration</i></p>	<p>*Please notify School Nurse *Give _____ per physician's orders *Notify parent/guardian</p>
<p><u>Indications of Flare-Ups or Worsening Symptoms</u> <i>Increase in coughing, wheezing, sputum production, fatigue or "feeling tired"</i></p>	<p>*Please notify School Nurse *Notify parent/guardian</p>

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** _____

School _____

Harrison County Schools Medication Form

Student Information

Student Name _____

Last

First

Middle

Birth Date _____ Homeroom Teacher _____ Grade _____

Medication Allergies _____

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 _____

Physician

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 _____

Parent/Guardian

Form Received and Reviewed by School Nurse _____ Date _____

Signature