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
Heart Condition Questionnaire

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

1. Has your student been diagnosed by a physician with any of the following **(✓ all that apply**)

□ Heart Murmur □ SVT (Supraventricular Tachycardia) □ Congestive Heart Failure □ Aortic Stenosis
□ Patent ductus arteriosis □ Septal defect □ Rheumatic heart disease □ Tetralogy of fallot
□ Transposition of the great arteries □ Coarctation of the aorta
□ Surgery- Type _____
□ Other (Specify) _____

2. Does your child have any restrictions/limitations required by their physician? **(✓only one)**

□ Cleared without limitation including all physical activities and recess.
□ NOT Cleared for (please be specific) _____

Doctor's letter/order is required if activity is limited

3. Your child's signs and symptoms of a cardiac episode are **(✓ all that apply)**

□ Chest tightness/pain □ Shortness of breath/difficulty breathing □ Tires easily □ Irritability
□ Change in activity tolerance □ Bluish coloring around mouth, lips or fingernails □ Fainting/dizziness
□ Swelling □ Heart arrhythmias (heart too fast, too slow, or irregular beats)

3. How often does your child have symptoms? _____
When was the last time? _____

4. Please list **ALL** the medications your child takes:

Name of medication:	Amount/dose	When taken:

Please note if medication must be given during school hours, an **Authorization of Medication form must be completed every school year**

5. Does your child have other health problems? _____

6. Are there other safety measures we need to address to protect your student during the school day?

_____

I understand and agree that information in this Heart Questionnaire will be shared with appropriate school staff.

_____ _____
Parent/Guardian Signature Date

School Nurse Received and Reviewed: _____ _____
School Nurse Signature Date

Feb 2016- White

Return To School Nurse

HARRISON COUNTY SCHOOL HEALTH SERVICES
EMERGENCY ACTION PLAN

CARDIAC

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

The student has the following restrictions/limitations: _____
The following safety measures need to be taken during the school day_____

EMERGENCY CONTACT INFORMATION

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

If School Nurse is in building please notify nurse immediately!

IF YOU SEE THIS:	DO THIS: ***Never send student anywhere alone!***
Shortness of Breath	***Encourage to lean slightly forward and breathe through pursed lips.** ***Contact parent with any episode.** ***Adult stays with student and watches for any worsening of symptoms.**
Chest Pain	***Allow to rest in whichever position is most comfortable** ***Contact parent with any episode.** ***Adult stays with student and watches for any worsening of symptoms.**
LIFE-THREATENING SYMPTOMS: **Sudden Severe Chest Pain** **Sudden Severe Shortness of Breath** **Loss of Consciousness**	**Activate Code Blue and Call 911**
BREATHING STOPS	**Activate Code Blue and Call 911** **Begin CPR/RESCUE BREATHING**

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

Feb 2016- White

Return To School Nurse

HARRISON COUNTY SCHOOL HEALTH SERVICES

EMERGENCY ACTION PLAN

HYPERTENSION/HYPERTENSIVE CRISIS

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

EMERGENCY CONTACT INFORMATION

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

IF YOU SEE THIS:	DO THIS:
Onset of Symptoms: • Headache • Flushed face • Dizziness	• **Move student to quiet, calm space** • **Encourage relaxation techniques** • **Remain with student until trained staff arrives. Trained staff may take student's blood pressure and report to school nurse and/or parent.** • **Administer Medication if indicated by MD order_____**
Hypertensive Crisis: • Severe headache with confusion and/or blurred vision • Severe Chest Pain • Severe anxiety • Shortness of breath • Seizures • Unresponsiveness	• **Notify School Nurse immediately if in the building** • **Activate Code Blue and 911** • **Remain with student until trained staff arrive** • **Trained staff may obtain blood pressure and document** • **Administer Medication if indicated by MD order_____** • **Notify parent**

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_____***

Revised Feb 2016- White

Return To School Nurse

HARRISON COUNTY SCHOOL HEALTH SERVICES
EMERGENCY ACTION PLAN

SVT (Supraventricular Tachycardia)

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

The student has the following restrictions/limitations: _____
The following safety measures need to be taken during the school day_____

EMERGENCY CONTACT INFORMATION

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

If School Nurse is in building please notify nurse immediately!

IF YOU SEE THIS:	DO THIS: ***Never send student anywhere alone!***
Shortness of Breath	***Encourage to lean slightly forward and breathe through pursed lips.** ***Adult stays with student and watches for any worsening of symptoms.** ***Call parent for any episode**
Chest Pain	***Allow to rest in whichever position is most comfortable** ***Adult stays with student and watches for any worsening of symptoms.** ***Call parent for any episodes**
Fast/Irregular Heart Rate	***Have student "bear down" as if trying to have a bowel moment. First have student lie down, take a deep breath and hold it, and then bear down as if you are having a bowel movement.** ***May need repeated if still symptomatic.** ***Call parent for any episode.** ***If available, have student blow through straw.**
LIFE-THREATENING SYMPTOMS: **Sudden Severe Chest Pain or Shortness of Breath** **Cyanosis (bluish color to lips/nails)** **Loss of Consciousness**	**Activate Code Blue & Call 911**
BREATHING STOPS	**Activate Code Blue & Call 911** **Begin CPR/RESCUE BREATHING**

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

Feb 2016- White

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