HARRISON COUNTY SCHOOLS

OFFICE OF HEALTH SERVICES
445 W. Main Street
Claraksburg, 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

Headache Questionnaire

Student Name: ___________________________ DOB: _______ Grade/Teacher: ________________________

1. Does your child have a diagnosis of migraines from a healthcare provider? □ Yes □ No

2. How long has your child been having headaches? ____

3. What is the location of their typical headache/migraine? □ Forehead □ Temple □ All Over
□ Back of Head □ One particular side? ___________________________

4. Triggers- Please check any that apply:
   □ Hormonal changes □ Lack of Sleep □ Medications □ Stress
   □ Physical Activity □ Sensory Stimulation (light, noise, etc) □ Food (please list) ________________
   □ Changes in environment □ Other__________________________________

5. When your child has a headache, does he/she have:

Nausea/vomiting	□ Yes	□ No
Problems Seeing	□ Yes	□ No
Dizziness	□ Yes	□ No
Abdominal Pain	□ Yes	□ No
Light Sensitivity	□ Yes	□ No

6. Is your child on daily Preventative Headache Medications? □**NO** □ **YES** (if YES, which ones? Please check all that apply)
□ Elavil (Amitriptyline) □ Pamelor (Nortriptyline) □ Topamax(Topiramate) □ Inderal (Propranolol)
□ Periactin (cyproheptidine) □ Depakote (Valproic acid) □ Neurontin (Gabapentine) □ Calan (Verapimil)
Other_____________________________________

7. Rescue Medications**:** What medications does your child use to treat headache pain? **None**
□ Advil/Motrin (ibuprofen) □ Tylenol (acetaminophen) □ Aleve/Anaprox (Naproxen) □ Aspirin
□ Benadryl(diphenhydramine) □ Compazine(prochlorperazine) □ Zofran (Ondansetron) □ Maxalt (Rizatriptan)
□Phenergan (promethazine) □ Indocin (Indomethacin) □ Imitrex (sumatriptan) □ Zomig (zolmitraptan)

8. Will your child need to have any rescue medications available at school? __________________________________

9. On average how many times a week does your child have a headache? ____________________________________

10. What generally helps your child feel better? ____

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

____ ______________________
Parent/Guardian Signature Date

School Nurse Received and Reviewed: _____________________________ ________________
School Nurse Signature Date

Feb 2016- Blue

Return To School Nurse

HARRISON COUNTY SCHOOL HEALTH SERVICES

EMERGENCY ACTION PLAN

HEADACHE/MIGRAINE

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:
Student has any of these: ***Complaints of head pain** ***Complaints of early migraine symptoms_________________________** ***Difficulty with school work/play** ***Light Sensitivity** ***Nausea**	***Student has available ______________________ (Medication) at school and should report to ________________. (Location)** ***Encourage student to drink water (if no nausea)** ***Call parent/guardian if symptoms persist or no medication available.** *** Place in quiet, dark room** ***Cool compress to head/neck**
<u>For Worsening Headache Symptoms:</u> **Any of the above symptoms, <u>plus</u>** ***Previously administered medicine is not helping** ***Vomiting**	***Student has a secondary pain medication available _____________________________ (Medication) at school and should report to ________________. (Location)** ***Notify Parent if symptoms worsen or vomiting**

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- Blue

School_________________________

Harrison County Schools Medication Form

Student Information

Student Name ____
Last First Middle

Birth Date ____________________ Homeroom Teacher _____________________________ Grade __________

Medication Allergies____

Physician

<u>This section of the Medication Form is to be filled out by a licensed prescriber.</u> 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 <u>any prescription and non-prescription (over the counter) medication.</u> If there is any change in medication, dosage, time, or route, a new medication order must be received <u>before</u> 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