July 2018

Dear Parents,

We hope you are enjoying your summer break and are finding some rest and relaxation with your family. It is hard to believe that in a few short weeks we will be back in school! We are excited to welcome the students back as we partner with you to help them be healthy and ready to learn.

If you could please email any medical changes to the email addresses below, this will allow us to have the most up-to-date information regarding the health of our students. In addition, please review the policies on line regarding student health concerns. **Also remember that hard copies of the health forms and Medication Authorizations forms must be turned into the office by the first day of school. (Forms attached) Without these forms your student will not be able to attend any off campus functions. Thanks for helping us keep your student safe.**

Regarding medications: NO MEDS will be given to students without proper paperwork and this paper work has to be turned in new each year with the physician's signature.

* If you have a student with allergies requiring an Epipen or asthma requiring an inhaler, please be sure to have your **Healthcare provider sign** the appropriate authorization forms.

* In addition, please remember that **NO Medication** (***over the counter or prescription***) will be given without the signature of *both* a **parent and an authorized Healthcare provider** (MD, PA, or APRN). There are no exceptions to this rule as it is in compliance with NC state law. This includes the rule that students are not allowed to carry and self administer any medications without a signed authorization on file at the school. Therefore, please complete the Medication Authorization form with both parent and medical provider signatures.

* All forms may be found on the website. There is a School Nurse page available on each of the "Connections" sites.

Regarding Illness:
* Please review the "Guidelines to Common Illnesses" found in the Student Parent Handbook and also available on the School Nurse page of the website. We follow these guidelines in order to maintain the healthiest environment possible for all students.

Finally, please call us if you have any concerns regarding your student. School Nurse Phone (704) 915-5880. We strive to help the students be comfortable while at school so they can learn. **All forms should be completed and returned by the first day of school**. Enjoy the remaining summer fun!

In His Service,

Sharon Spear RN Sspear@gastonchristian.org

GASTON CHRISTIAN SCHOOL

MEDICATION AUTHORIZATION

*No medications (non-prescription/over the counter or prescription) will be administered by the school nurse, other school personnel or self (student) without the written authorization of a **physician and parent**.*

Student's Name_____**Grade**_____

Drug Allergies_____

Date of Birth_____**Height**_____**Weight**_____

Parent Complete

I, _____(do___) (do not___)authorize my child's health care provider and the school nurse to discuss my child's health concerns and/or exchange information pertaining to school health forms. *This authorization will be in place until or unless you withdraw it. You may withdraw your authorization at any time by contacting your child's school.* **I authorize the medication(s) checked below by the care provider to be given as ordered to my child.**

Signature of parent/legal guardian_____Date_____

Physician/Provider Complete

The over the counter medication dosage will be administered according to the manufacturer's recommendations on the label unless otherwise indicated by a physician. Generic substitutions may be used for non-prescription medications listed. This form will also be the authorized form used for off campus activities, including overnight trips.

Non-prescription medication stocked in office include the following (**please check** those that are to be given as needed):

☐ Tylenol (Acetaminophen) ☐ Motrin (Ibuprofen) ☐ Benadryl

☐ Cough drops ☐ Tums

☐ Neosporin/Hydrocortisone lotion/Benadryl spray and lotion/topical sting relief

Please list **any other medication** which would need administering during school or school related activities, whether to be administered by school personnel or self (student).

Name of medication_____Dosage_____

Route_____Hours to be given_____

Student may carry and self administer the medication ordered: yes_____ no_____

Physician/Nurse Practitioner/PA

Signature_____Date_____

GASTON CHRISTIAN SCHOOL

Medical Information/Emergency Release Form

Student's legal name _____ **Prefers to be called**_____

Home phone:_____ Date of birth ____/____/____ **Grade** _____ **Gender** (please circle): M F

Address_____ City_____ State_____ Zip Code_____

Parent information:

	Name	**Legal Guardian**	**Cell**	**Work**
Mother		Y/N		
Father		Y/N		
Step-parent		Y/N		

	Name	Phone
Pediatrician/primary care provider		
Dentist		

Insurance Company:_____

Policy number_____Phone_____

Emergency contact who will assume responsibility if parent cannot be reached:

Name: _____ home_____ cell_____

Name: _____ home_____ cell_____

Date of last tetanus shot: _____

(In case of accident or serious illness, the school will contact the parent/guardian. If the school is unable to contact the parent/guardian or person designated above, the school will make necessary arrangements for immediate treatment. Payment of any fees will be assumed by the parent/guardian.)

I hereby give my consent to any hospital and/or licensed physician or authorized provider to administer necessary emergency treatment to my child in the event such treatment is imperative and I cannot be contacted.

Parent/guardian signature: _____ Date _____

GASTON CHRISTIAN SCHOOL

Name _____

Medical History

Please indicate below (X) if your student has any of the following, and describe any treatments/medications, or special considerations:

	Asthma (worsened by exercise? Y N) (*Inhaler? Y N)
	Allergies (list all)_____(*EpiPen? Y N)
	Cardiac Issues
	Diabetes
	Gastrointestinal Issues
	Hearing Issues
	Kidney/Bladder Issues
	Migraines
	Orthopedic Issues
	Seizures
	Vision Issues (glasses/contacts/other _____)
	Other (list:_____)

***If your child requires having an inhaler and/or EpiPen at school, please have your physician complete the authorization form/treatment plan; these can be found on the website or obtained from the school nurse.**

Surgical history: Type(s)_____Year(s)_____

Disabilities or restrictions: _____

Monitoring devices or medical equipment to be used while at school? _____

Medications your student takes regularly: _____

Any other information about your child that would be helpful for the school nurse to know:

_____

No medications (over the counter or prescription) will be administered by the school nurse, other school personnel, or self administered by the student without the written authorization of a parent and physician/authorized provider. All prescription medications must be brought to school in the original container with the student's name and prescription information on the label.

All over-the-counter medication dosages will be administered according to the manufacturer's recommendations on the label unless otherwise indicated by a physician. Generic substitutions may be used for non-prescription medications listed. These forms will also be the authorized form used for off campus activities, including overnight trips. ****Medication Authorization forms can be found on the website or obtained from the school nurse****

Parent/guardian signature_____Date_____

GASTON CHRISTIAN SCHOOL

EpiPen Authorization

SECTION 1—PARENTS OR GUARDIAN TO COMPLETE

I hereby authorize Gaston Christian School personnel to administer emergency epinephrine injections as directed by the physician (section II). I agree to release, indemnify, and hold harmless GCS and any of their officers, staff members, or agents from lawsuit, claim expense demand or action, against them for administering the injection, provided they follow the physicians's order as written in section II below. I am aware that a non-health professional may administer the injection. This form will also be the authorized form used for off campus activities, including overnight trips.

I understand that emergency medical services (EMS) will always be called when epinephrine is given.

Student Name | Date of birth

Parent or Guardian signature | Daytime telephone | Date

SECTION II—PHYSICIAN/NURSE PRACTITIONER/PHYSICIAN ASSISTANT TO COMPLETE

Effective date: From _____ To_____

The injection will be given immediately after report of <u>exposure with reaction</u> to:

_____.

Route of exposure (circle): ingestion / skin contact / inhalation / insect sting or bite

Check appropriate boxes:

☐ **EpiPen**
- Give the pre-measured dose of 0.3 mg epinephrine by autoinjection

☐ **EpiPen Jr**.
- Give the pre-measured dose of 0.15 mg epinephrine by autoinjection

Check appropriate box:

This student has received adequate information on how and when to use an EpiPen and has demonstrated use.

☐ The student is to carry EpiPen during school. The student can use the EpiPen properly in an emergency.

☐ The EpiPen will be kept in the school health room or other school-approved location.

Physician/Nurse Practitioner/Physician Assistant Signature: **Date:**

GASTON CHRISTIAN SCHOOL

Inhaler/Nebulizer Authorization

SECTION I—PARENTS OR GUARDIAN TO COMPLETE

I hereby authorize Gaston Christian School personnel to administer or permit the student identified below to use an inhaler as prescribed (section II). I agree to release, indemnify, and hold harmless GCS and any of their officers, staff members, or agents from lawsuit, claim expense demand or action, etc. against them for assisting this student with the inhaler, provided they follow the physicians's order as written in section II below.

Student Name:_____Date of birth:_____

Parent or Guardian signature:_____

Daytime telephone :_____Date_____

SECTION II—PHYSICIAN/NURSE PRACTITIONER/PHYSICIAN ASSISTANT TO COMPLETE

This form will also be the authorized form used for off campus activities, including overnight trips.

Asthma/Reactive Airway Exercise Induces: yes no

Medication ordered: _____

Dosage to be given at school:_____

Time interval for repeating dosage: _____

Special instructions: _____

This student has received adequate information on how and when to use an inhaler and has demonstrated that he or she can use it properly.

*Student may carry and self-administer the inhaler: Yes_____ No_____

Physician/Nurse Practitioner/Physician Assistant Signature:	**Date:**

Guidelines for Common Illnesses

ILLNESS	INCUBATION PERIOD	MODE OF TRANSMISSION	RESTRICT FROM SCHOOL?	RETURN TO SCHOOL	PREVENTION OF TRANSMISSION
Temperature over 100˚			YES	**Once fever free for 24 hours without fever reducing medications**	Handwashing and dependent on underlying cause
Vomiting and/or diarrhea			YES	Once it has been 24 hours since last episode of vomiting and/or diarrhea	Handwashing
Common Cold	12 hours to 5 days	Respiratory tract, droplets, indirectly by contaminated hands or surfaces	NO	N/A	Hand washing, covering nose and mouth when sneezing or coughing
Conjunctivitis (pink eye)	24-48 hours	Contact with discharge from eyes	YES	24 hours after the start of antibiotic therapy	Treatment of the affected eye, hand washing, disinfecting contaminated surfaces, avoid contact with eye drainage
Influenza (seasonal and/or H1N1)	24-72 hours	Droplets, Respiratory tract	YES	When fever and symptom free for 24 hours without Fever reducing meds	Good hand washing, covering nose and mouth when sneezing or coughing, Immunization unless contraindicated
Head Lice (Pediculosis)	7 days for eggs to hatch.	Direct contact with infested person is most common	YES	24 hours after application of effective pediculicide; no live lice present	Avoid head to head contact; do not share clothing, hats, combs/brushes, or towels.
Chickenpox (Varicella)	From 2-3 weeks; commonly 14-16 days	Person to person by direct contact, droplet, or airborne spread of secretions	YES	After all vesicles become dry/crusty	Avoiding contact with infected person; covering coughs and sneezes. Immunization unless contraindicated.
Rash			YES	Once evaluated and cleared to return to school by physician	Avoiding contact with the affected person
Strep Throat		Person to person contact	YES	24 hours after beginning antibiotic therapy	Avoiding contact with the affected person