Valley Collaborative
Health Office
40 Linnell Circle, Billerica MA 01821 * Tel: (978)-528-7808 * http://www.valleycollaborative.org

Dear Parents/Guardians,

Welcome to the 2022-2023 school year at Valley Collaborative! Please find our health forms enclosed. Every year we require new forms to be filled out so we can ensure that we have up to date parent/guardian contact information, medication, and any other changes that may have occurred in the past year. Our number one goal is the safety of our students. If information changes throughout the school year, please notify your school nurse.

If your student requires medications during the school day or has a special medical condition such as allergies, or seizures please contact the health office at your child's school as additional forms may be required. All physicians' orders to administer medication during school hours should be renewed for the 2022-2023 school year.

- Please be aware that the *Parental Permission for Standing Orders* form must be signed by a parent or guardian for the nurse to administer any of the over-the-counter medications such as Tylenol or Advil.

- Up to date *Immunization records* are required to be on file in the health office. Please notify your school nurse when a new immunization is given in writing via immunization record.

- *Physicals* are required within the first year of enrollment and every three years thereafter.

All medical forms included in this packet are required by the Mass. Dept. of Public Health. The Massachusetts school physical record and immunization record sheets are attached in this packet. Contact your student's school nurse if you are unsure the status of your child's records.

All forms should be sent to your student's school health office. Do not hesitate to call the health office with any questions. Completed packets must be returned prior to the start of the summer program.

Stay Healthy,

Jessica Scalzi RN, BSN

Jessica Scalzi RN, BSN, NCSN
Valley Collaborative Lead Nurse
978-528-7896
jscalzi@valleycollaborative.org

NURSE USE ONLY:
Grade: _____
Program: _____
SASID: _____
IHCP: yes ☐ **no** ☐

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EMERGENCY MEDICAL INFORMATION
School Year 2022-2023

Student's Name:_____Date of Birth: _____ Gender: _____

Address:_____Town/City: _____ State/Zip: _____

Contact #1 -Parent/Guardian Name:_____Relationship: _____
Address:_____
Email Address:_____
☐ Home phone#:_____
☐ Work phone#:_____
☐ Cell phone#:_____

Contact #2 -Parent/Guardian Name:_____Relationship:_____
Address:_____
Email Address: _____
☐ Home phone#:_____
☐ Work phone#:_____
☐ Cell phone#:_____

Emergency Contact (if parents cannot be reached) -Name:_____
Telephone#:_____Relation to student:_____
(Please use back of form if more room is needed.)

Does your child wear glasses? ☐ Yes ☐ No Any other assisted devices? _____

Allergies/Asthma: ☐ yes ☐ no (If yes, please list below) **(Nurse use only:** ☐ **Asthma/Allergy Action Plan in Place)**

Allergy/Asthma	Describe Reaction	Treatment

(Please use back of form if more room is needed.)

Seizure Activity: ☐ yes ☐ no (If yes, please describe): **(Nurse use only:** ☐ **Seizure Action Plan in Place)**

Describe Seizure	Treatment

Medical/Social/Emotional/Mental Health Diagnoses:

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Student's Name:_____Date of Birth:_____

Medication (Please list *all* medication taken by student. Medications taken at school require a physician's order)

Medication Name	Dosage	Frequency	Time Taken	Reason for Medication

Dietary restrictions or feeding concerns:

_____

_____

Insurance Information (to be used in the event of emergency hospitalization):

Insurance Company:_____Policy#:_____

Policy Holder: _____

Medical Specialists

Primary Care Physician: _____Telephone#:_____Fax#:_____

Dentist:_____Telephone#:_____Fax#:_____

Psychiatrist_____Telephone#: _____Fax#:_____

Other:_____Telephone#:_____Fax#:_____

EMERGENCY MEDICAL TREATMENT CONSENT

I understand that in the case of a Medical Emergency, requiring treatment or hospitalization, student will be taken to the nearest treatment facility and given all lifesaving measures, unless otherwise indicated.

Parent/ Guardian Signature: _____ Date: _____

RELEASE OF RECORDS

I give Valley Collaborative my permission to exchange medical information with the individual's medical team and/or sending school for the purpose of sharing pertinent information necessary for proper treatment.
Any information obtained by Valley Collaborative will be held in the strictest confidence.

Parent/Guardian Signature:_____Date:_____

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Student's Name:_____Date of Birth:_____

PARENTAL PERMISSION for STANDING ORDERS

Nurses may administer the following over the counter medication as needed with parental/guardian permission. Please draw a line through any item you do not want given.

1. Acetaminophen (Tylenol) every 4 hours for complaint of pain or fever over 100.5 degrees.
   Dosage: Under 25lbs. give 10mg. per 2lbs. 30-40 lbs. give 160mg. 41-60lbs. give 240mg.
   Over 60lbs give 325- 650mg. Not to exceed 4g/day
2. Ibuprofen (Motrin/Advil) every 6 hours for complaint of pain or fever over 100.5.
   Dosage: Child 6 mo.-12 yrs 5mg/kg. Child over 12 yrs 200-400mg. Not to exceed 3.2g/day
3. Oral pain reliever for tooth pain or mouth sores as needed.
4. Calcium Carbonate antacid (Tums) for indigestion up to 2 tabs for one dose only.
5. Diphenhydramine (Benadryl) every 4 hours as needed for *allergic reactions: itching, and/or hives.*
   Dosage: Child under 50lbs. give 12.5 mg (5cc) Child over 50lbs. give 25mg (10cc)
6. Cough drops as needed for throat discomfort/cold symptoms.
7. Caladryl as needed for itch.
8. Hydrocortisone 1% as needed for itch
9. Hand Sanitizer up to 70% alcohol, I pump dispersed in hands

***Items that may be carried by student during school hours only after nurse consultation.**
Supplies must be provided by the family:

1. Rescue Inhaler: Must be accompanied by an MD order and Asthma Action Plan
   Dosage: as prescribed by MD
2. Enzymes: must be accompanied by an MD order
   Dosage: as prescribed by MD
3. Diabetes testing supplies and Insulin: must be accompanied by an MD order and Diabetes treatment plan.
4. Epi-Pen: must be accompanied by an MD order and Allergy Action Plan

Dosage and administration for anaphylactic reaction, laryngeal edema, or hives:

Preschool: 0.1ccIM or SC
Elementary/Middle School: 0.15cc IM or SC (weight less than 50lbs.)
High School/Adult: 0.3cc IM or SC (weight greater than or equal to 50lbs.)
**Repeat injection in 5-15 minutes if the child's condition has not improved/deteriorated and EMS has not arrived yet.
Heart rate must be less than 180 beats per minute.*

Parent/Guardian Signature:_____Date:_____

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PHYSICIANS MEDICATION ORDER FORM

Name of Student:_____ Date of Birth: _____

Address:_____ Telephone _____

Physician/Clinic:_____ Telephone _____

Allergies/Adverse medication reactions: _____

MEDICATIONS TO BE GIVEN DURING SCHOOL HOURS

Date	Medication & Dose	Route & Frequency	Treatment Purpose	Special instructions (Including parameters for vital sign monitoring, if needed)	Duration/Stop Date

Unless indicated by Physician, above medications may be administered by trained staff.

MEDICATIONS BEING TAKEN BY STUDENT AT HOME

Medication & Dose	Route & Frequency	Treatment Purpose	Prescribed by

Physicians Signature:_____Date:_____

Parental/Guardian Signature: _____Date_____

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PARENT/GUARDIAN AUTHORIZATION FOR PRESCRIPTION MEDICATION/TREATMENT ADMINISTRATION

Student's Name:_____Date of Birth:_____.....

Please initial all that apply:

☐ I consent to have the program nurse or trained school personnel designated by the program nurse administer prescribed medication to my student.

☐ I give my permission for student to self-administer medication/self-treat, if the program nurse determines it is safe and appropriate.

☐ I give permission to the program nurse to share information relevant to the prescribed medication/treatment administration as he/she determines appropriate for student's health and safety.

The school may only hold a thirty day supply of medication and that medication must be delivered to the program nurse by a parent/guardian or sent with student in a locked box provided by the family.

Parents/Guardians may retrieve the medication from the school at any time: however, the medication will be destroyed if it is not picked up within one week following termination of the order.

Parent/Guardian signature:_____Date:_____

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Seizure Protocol

PROTOCOL:

1. All individuals' physical safety will be insured at all times.
2. **For seizure lasting more than 5 minutes 911 will be called & individual will be transported to nearest hospital.** (An exception will be made if a physician specifies in a physician's order.)
3. For students who exhibit any seizure like activity and do not have a current seizure diagnosis **911 will be called immediately & individual will be transported to nearest hospital.**
4. Guardian/parent will be notified whenever any seizure activity has taken place.
5. Students with a diagnosed seizure activity must have protocol signed by Physician, in addition to an Individualized Health Care Plan, on file.
6. When possible, two staff members should be present when an individual is having a seizure, one staff to maintain safety, one staff to make phone calls if necessary.

PROCEDURE:

1. As soon as seizure activity is noted, a safe position will be established either in their chair or on the floor.
2. Remove any furniture or equipment that may pose as a safety issue.
3. Loosen clothing around neck and chest and release body jacket if wearing one.
4. Turn person onto side or if sitting tip head slightly forward.
5. Never place anything in the mouth (tongue depressor or airway).
6. Do not try to restrict the person's movements.
7. Stay with the person until motor segment of the seizure is over.
8. During the seizure observe the characteristics of the seizure including the following:
   - ❑ Precipitating factors (fever, menses, loud noise, bright lights etc..)
   - ❑ Time of onset
   - ❑ Aura
   - ❑ Clinical progression of the seizure activity (from arm twitching to generalized activity) skin pallor, cyanosis of tongue or around the mouth
   - ❑ Loss of consciousness
   - ❑ Duration of motor activities
   - ❑ Post-ictal state (sleepy, lethargic, confusion, crying, vocalizing, and headache).
9. Document the seizure on Seizure Activity Flow sheet.
10. As per protocol, inform parents/guardian that seizure activity has occurred.

Student's/Client's Name:_____ Date of birth:_____
Parent/Guardian Signature:_____ Date:_____
Students with a diagnosed seizure activity must have protocol signed by Physician. ***Form valid for one year from date signed.***

Physician Use only

Please use the above protocol for my patient.
Please follow alternate protocol for my patient. Protocol is attached.
Physician's additional instructions: _____

Physician's Signature:_____ Date:_____

MASSACHUSETTS SCHOOL HEALTH RECORD
Health Care Provider's Examination

Name _____ ☐ Male ☐ Female Date of Birth:_____
Medical History _____

Pertinent Family History

Current Health Issues

Y **N**

☐ ☐ Allergies: Please list: Medications_____Food_____Other _____
History of Anaphylaxis to_____Epi-Pen®: ☐ Yes ☐ No

☐ ☐ Asthma: Asthma Action Plan ☐ Yes ☐ No (*Please attach*)

☐ ☐ Diabetes: ☐ Type I ☐ Type II

☐ ☐ Seizure disorder: _____

☐ ☐ Other (*Please specify)* _____

Current Medications (if relevant to the student's health and safety) *Please circle those administered in school; a separate medication order form is needed for each medication administered in school.*

Physical Examination **Date of Examination:**_____

Hgt:_____(_____%) Wgt:_____(_____%) BMI:_____(_____%) BP: _____

(Check = Normal / If abnormal, please describe.)

☐ General _____ ☐ Lungs _____ ☐ Extremities _____
☐ Skin _____ ☐ Heart _____ ☐ Neurologic _____
☐ HEENT _____ ☐ Abdomen _____ ☐ Other _____
☐ Dental/Oral _____ ☐ Genitalia _____

Screening:

	(Pass)	(Fail)
Vision: Right Eye	☐	☐
Left Eye	☐	☐
Stereopsis	☐	☐
Hearing: Right Ear	☐	☐
Left Ear	☐	
Postural Screening: (Scoliosis/Kyphosis/Lordosis)	☐	☐

Laboratory Results: ☐ Lead _____ Date _____ ☐ Other_____

The entire examination was normal: ☐

Targeted TB Skin Testing: ☐ Med-to-High risk (exposure to TB; born, lived, travel to TB endemic countries; medical risk factors):
Date of PPD:____; Results:____mm.
Referred for evaluation to: _____ ☐ Low risk (no PPD done)

This student has the following problems that may impact his/her educational experience:
☐ Vision ☐ Hearing ☐ Speech/Language ☐ Fine/Gross Motor Deficit
☐ Emotional/Social ☐ Behavior ☐ Other

Comments/Recommendations:_____

☐ Y ☐ N **This student may participate fully in the school program, including physical education and competitive sports. If no, please list restrictions:**_____

☐ Y ☐ N **Immunizations are complete: If no, give reason: Please attach Massachusetts Immunization Information System Certificate or other complete immunization record**.

_____ _____
Signature of Examiner *Circle:* MD, DO, NP, PA Date *Please print name of Examiner.*

_____
Group Practice Telephone

_____
Address City State Zip Code

Please attach additional information as needed for the health and safety of the student. *MDPH 12/14/04*

CERTIFICATE OF IMMUNIZATION

Name: **Date of Birth: / / Sex: M F**

Please indicate vaccine type (e.g., DTaP-Hib, etc.)

Vaccine		Date	Vaccine Type
Hepatitis B (e.g., HepB, HepB-Hib, DTaP-HepB-IPV, HepA-HepB)	1		
	2		
	3		
	4		
Diphtheria, Tetanus, Pertussis (e.g., DTP, DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, DTaP-IPV/Hib, DTaP-IPV, Td, Tdap)	1		
	2		
	3		
	4		
	5		
	6		
	7		
***Haemophilus influenzae* type b** (e.g., Hib, HepB-Hib, DTaP-Hib, DTaP-IPV/Hib)	1		
	2		
	3		
	4		
Polio (e.g., IPV, DTaP-HepB-IPV, DTaP-IPV/Hib, DTaP-IPV)	1		
	2		
	3		
	4		
	5		
Pneumococcal Conjugate (e.g., PCV7, PCV13)	1		
	2		
	3		
	4		

Vaccine		Date	Vaccine Type
Rotavirus (e.g., RV5: 3-dose series, RV1: 2-dose series)	1		
	2		
	3		
Measles, Mumps, Rubella (e.g., MMR, MMRV)	1		
	2		
Varicella (e.g., Var, MMRV)	1		
	2		
Meningococcal Conjugate (MCV4) or Polysaccharide (MPSV4)	1		
	2		
Seasonal Influenza Inactivated (Intramuscular) or Live (Intranasal)	1		
	2		
	3		
	4		
H1N1 Influenza Inactivated (Intramuscular) or Live (Intranasal)	1		
	2		
Pneumococcal Polysaccharide (PPSV23)	1		
	2		
Hepatitis A (e.g., HepA, HepA-HepB)	1		
	2		
Human Papillomavirus (e.g., HPV quadrivalent, HPV bivalent,)	1		
	2		
	3		
Other:			

Serologic Proof of Immunity		Check One	
Test (if done)	Date of Test	Positive	Negative
Measles	/ /		
Mumps	/ /		
Rubella	/ /		
Varicella*	/ /		
Hepatitis B	/ /		
* Must also check Chickenpox History box.			

Chickenpox History

☐ Check the box if this person has a physician-certified reliable history of chickenpox.

Reliable history may be based on:

- physician interpretation of parent/guardian description of chickenpox
- physical diagnosis of chickenpox, or
- serologic proof of immunity

I certify that this immunization information was transferred from the above-named individual's medical records.

Doctor or nurse's name *(please print)*: **Date: / /**

Signature:

Facility name: