# Student Health Packet

Valley
COLLABORATIVE

*Building a community that empowers children and adults to find their own way.*

Dear Parents/Guardians,

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 you 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.

- 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 Students can be denied entrance to programs if immunization records are not on file.

- **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. *Please be advised that if we do not have up to date immunization forms on file your son/daughter may be denied entrance to the school, until the forms are received.*** 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 PACKET MUST BE RETURNED PRIOR TO THE STUDENT'S FIRST DAY OF ATTENDANCE.

Thank you,

Jessica Scalzi RN, BSN
Valley Collaborative Lead Nurse

Valley Collaborative
Health Office

*40 Linnell Circle, Billerica MA 01821 * Tel: (978)-528-7800 * http://www.valleycollaborative.org*

**PAPERWORK CHECKLIST AND INSTRUCTIONS FOR RETURNING STUDENT PACKET**

Parents/Guardians,

Below is a list of the attached forms and notices along with instructions. *Starred documents are required to be on file for all students.* Please contact the nurse if you have not received any of these documents. Thank you.

- ❑ Paperwork checklist
- ❑ Intro letter from nurse *(keep for reference)*
- ❑ Absence/Tardy Call out Policy *(keep for reference)*
- ❑ * Emergency Medical Information *(2 pages, complete, sign & return)*
- ❑ * Copy of Guardianship paperwork *(if student is over 18 and under legal guardianship)*
- ❑ * Communicable Disease Policy *(keep for reference)*
- ❑ * Standing Orders Parental Permission *(sign and return, cross out items you do not agree to)*
- ❑ * Seizure Protocol *(sign and return, **if student has an active seizure disorder MD also must sign**)*
- ❑ Physician's Medication Order Form *(MD complete and sign if medications to be taken during school hours)*
- ❑ Parent /Guardian Authorization for Prescription Medication Administration *(complete and return only if student receives medication during school hours)*

Thank you,

Valley Collaborative Nursing Team

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**EMERGENCY MEDICAL INFORMATION**

Student's Name:_____Date of Birth:_____
Address:_____Telephone#:_____

**Contact #1** -Parent/Guardian Name:_____
Address:_____
Email Address (optional):_____
(In boxes below please list preferred contact order 1- being first 3- being last)
☐ Home phone#:_____
☐ Work phone#:_____
☐ Cell phone#:_____

**Contact #2** -Parent/Guardian Name:_____
Address:_____
Email Address (optional):_____
(In boxes below please list preferred contact order 1- being first 3- being last)
☐ Home phone#:_____
☐ Work phone#:_____
☐ Cell phone#:_____

**Emergency Contact (if parents cannot be reached)** -Name:_____
Telephone#:_____Relation to student:_____

**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 |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

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

**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 |
|---|---|
| | |

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Student's Name:_____Date of Birth:_____

**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#:_____

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.

**RELEASE OF RECORDS**

I, **(circle one)** DO / DO NOT give the 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:_____

**If you do not wish for your student to receive ANY medical treatment while attending Valley Collaborative Programs please sign the declination form below.**

**HEALTH CARE DECLINATION**

I,_____, prefer that,_____not

Receive any health care during school hours. In the event of an illness or injury while at school please contact me at the following number(s):_____

Parent/Guardian Signature:_____ Date:_____

***Please note: This form will expire one year from date signed. Please inform Nursing Department of any changes. Please see School***

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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. Hydrocortisone 1% as needed for itch

***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 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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Student's Name: _____ Date of Birth: _____

## COMMUNICABLE DISEASE PROTOCOL

**POLICY:** In order to prevent the spread of communicable, disease students with a diagnosed communicable disease will be advised to stay home for the following period of time as listed in the table below.

| Communicable Disease | Requirements |
|---|---|
| Bacterial Conjunctivitis | May return to school after medical treatment has been provided for 24 hours. |
| Chicken Pox | May return to school after all lesions have dried and crusted or one week from appearance of first eruption. |
| German Measles | May return to school after rash has disappeared. |
| Measles | May return to school four days after first appearance of rash |
| Impetigo | May return to school after all open sores have healed or is small enough that a band-aid will cover the entire area |
| Strep Throat | May return to school after antibiotic treatment has been given for 24 hours. |
| Ringworm | May return to school after treatment with antifungal cream has begun; lesions should be covered. |
| Pediculosis /Scabies | May return to school when treated; scabies must be treated with anti-parasitic for 24 hours before student may return to school or after one treatment. |

## DISMISSAL FROM SCHOOL PROTOCOL

**POLICY:** The Program nurse may exclude a student from school for health reasons if the student:

- Has returned from a hospital admission within the past 24 hours. This does not include routine tests or minor injuries. The student will remain at home for observation for the first 24 hours.
- Has a temperature of 100.5 degrees tympanic (by ear). Temperature must be 98.6 for a full 24 hours prior to returning to school. The exception is a child with a hypothalamic problem (temperature regulation problem) and is symptom free. Each case will be discussed individually.
- Has an infectious disease (Strep Throat/Pneumonia, etc.) and has not been on antibiotic therapy for 24 hours or as designated by MD. Eye drainage yellow/green in color with pink or red eyes, eyelids, etc.
- Any undiagnosed rash.
- Has a culture(s) pending (exceptions can be made at the discretion of the nurse).
- Is on respiratory precautions, cough/cold or has a significant change in respiratory secretions (green/yellow nasal drainage).
- Has Chicken Pox/Shingles, with active, draining rash (rash must be dry, non-weeping, and shingles must be covered). Students may attend school with poison ivy as it is not contagious. It should be washed thoroughly and covered.

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- Is experiencing significant seizures activity with medication adjustments (requires note from M.D. stating seizures and meds are stable).
- Has had persistent vomiting and diarrhea; must be symptom free for 24 hours before returning to school.
- Has a condition requiring immediate medical intervention, i.e., emergency dental care, sutures, bone setting, or pending a medical diagnosis for any condition.
- Has a condition that requires on-going supervision, which cannot be supervised in the school setting. Is very sleepy or is experiencing excessive bleeding after a dental visit.
- Has untreated Pediculosis, Scabies or body lice.
- Poses a significant health risk to others in the normal course of school activities.

Significant health risk is defined by:

- Any student is in the infectious stage of a serious airborne transmitted disease (T.B., Viral Pneumonia, Influenza, etc.).
- Students who are unable to hygienically manage their bowel and bladder functions and/or are in the infectious stage of an oral/fecal transmitted disease. Such diseases are, but are not limited to, Hepatitis A, Clostridium Difficile (c-diff), gastro-intestinal viruses (Salmonella, Shigella, Rotovirus) and parasites (Pinworms, Girdiasis.) and has not completed treatment.
- Students who have a disease which may be transmitted by body fluids, and have open lesions and whose developmental level makes it difficult for them to refrain from touching lesions and others, therefore, spreading the underlying infection to others. Such diseases are, but not limited to, Herpes, Impetigo, Hepatitis B virus, Staph Aureus, Beta Hemolytic Strep, and Conjunctivitis.

*I have read and understand the above Communicable Disease Protocol and Dismissal from School Protocol.*

***Please note: This form will expire one year from date signed. Please inform Nursing Department of any changes. Please see School Nurse Roster for contact information.***

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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_____

***Please note: This form will expire one year from date signed. Please inform Nursing Department of any changes.***

***Please see School Nurse Roster for contact information.****

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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:_____

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# 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:**