PARENTS: A NOTE FROM THE HEALTH NURSE

Hello, I am the health nurse at Seneca East. Your child's health and well-being are very important to me and I make every student a priority. I encourage parents to take their children to seek medical attention when they are sick and obtain regular check- ups. A healthy child is better able to learn.

If your child has been to visit a physician or specialist please let me know. If you obtain a "visit summary" share it with me so I can better understand your child and give them the best care possible while at school. The physician's office can fax them to me at 419-426-5400 if they would like.

If you have any questions or concerns,feel free to contact me at 419-426-1866 or email me at aferres@se-tigers.com.

Stay Healthy,

Amy Ferres, RN - Health Nurse

KEEP STUDENT HOME IF......

I Have a FEVER	I am VOMITING	I Have DIARRHEA	I Have a RASH	I Have HEAD LICE	I Have an EYE INFECTION	I Have Been in the HOSPITAL
Temperature of 100.4 or higher	Within the past 24 hours	Within the past 24 hours	Body rash with itching or fever	Itchy head with live lice	Redness, itching and "crusty" drainage from eyes	Hospital stay and/or ER Visit

STUDENT IS READY TO RETURN TO SCHOOL WHEN......

Fever free for 24 hours without the use of fever reducing medication – Tylenol, Motrin	Free from vomiting for 24 hours	Free from diarrhea for 24 hours	Free from rash, itching or fever. Checked by a doctor if needed	Treated with lice treatment at home and proof is given to the nurse *No Live Lice*	Evaluated by a doctor and has been on antibiotic eye drops for 24 hours	Released by medical provider to return to school. Need note.

Call the school nurse if you have any questions or concerns and to inform of any changes in your child's health history.

Borrowed from Rita Schank RN - Mohawk School Nurse

School/State Medication Administration Policy

1. All medications MUST be brought to school by a parent/guardian or adult- NOT the student.
2. Parent/guardian or adult - NOT the student is to pick up unused medication at the end of the school year or when the medication is changed or discontinued by the physician.
3. Medication that is not picked up at the end of the school year will be discarded. It can not be "saved" for the next school year.
4. Students are NOT to have any medication in their possession, take or carry medications without the knowledge of the nurse and proper forms completed.

All medication forms need to be filled out by a parent/guardian and all prescription medications need a physician/healthcare provider form filled out before the medication can be given at school. Any medication changes during the school year will need new medication forms completed. Medication forms can be found on the school website under heading "NURSE". It is the parent/guardian's responsiblity to have the medication forms completed by the physician.

Over the counter medication MUST be in an unopened bottle/box and will be administered per medication label instructions. Medication cannot be expired.

Prescription medication MUST be in a labeled container from the pharmacy. Prescription dates MUST be current and medication can not be expired.

Any questions, please call the health nurse at 419-426-1866 or email aferres@se-tigers.com.

Thank you,
Amy Ferres,RN

MEDICATION ADMINISTRATION RECORD (MAR)
GENERAL MEDICATION FORM
(Including Asthma Inhaler and Epinephrine Autoinjector Use)

Student Information

Student name				Date of birth
Student address				
School	Grade/Class	Teacher		School year
List any known drug allergies/reactions			Height	Weight

Prescriber Authorization

Name of medication	Circumstance for use	
Dosage	Route	Time/Interval
Date to begin medication	Date to end medication	
Circumstances for use		
Special instructions		
Treatment in the event of an adverse reaction		

Epinephrine Autoinjector
☐ Not applicable
☐ Yes, as the prescriber I have determined that this student is capable of possessing and using this autoinjector appropriately and have provided the student with training in the proper use of the autoinjector.

Asthma Inhaler
☐ Not applicable
☐ Yes, if conditions are satisfied per R.C. 3317.716, the student may possess and use the inhaler at school or at any activity, event or program sponsored by or in which the student's school is a participant.

Procedures for school employees if the student is unable to administer the medication or if it does not produce the expected relief

Possible Severe Adverse Reaction(s) per R.C. 3317.716 and 3313.718
a) To the student for whom it is prescribed (that should be reported to the prescriber)

b) To a student for whom it is not prescribed who receives a dose

Other medication instructions
Does medication require refrigeration? ☐ Yes ☐ No Is the medication a controlled substance? ☐ Yes ☐ No

Prescriber Signature	Date	Phone	Fax

Prescriber name (print)

Reminder note for prescriber: R.C. 3313.718 requires backup epinephrine autoinjector and best practice recommends backup asthma inhaler.

Parent/Guardian Authorization

☑ I authorize an employee of the school board to administer the above medication. ☑ I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed. ☑ I also authorize the licensed healthcare professional to talk with the prescriber or pharmacist to clarify medication order.

☑ Medication form must be received by the principal, his/her designee, and/or the school nurse. ☑ I understand that the medication must be in the **original** container and be properly labeled with the student's name, prescriber's name, date of prescription, name of medication, dosage, strength, time interval, route of administration and the date of drug expiration when appropriate.

Parent/Guardian Signature	Date	#1 contact phone	#2 contact phone

Parent/Guardian Self-Carry Authorization

☐ For Epinephrine Autoinjector: As the parent/guardian of this student, I authorize my child to possess and use an epinephrine autoinjector, as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school is a participant. I understand that a school employee will immediately request assistance from an emergency medical service provider if this medication is administered. I will provide a backup dose of the medication to the school principal or nurse as required by law.

☐ For asthma Inhaler: As the parent/guardian of this student, I authorize my child to possess and use an asthma inhaler as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school is a participant.

Parent/Guardian signature	Date	#1 contact phone	#2 contact phone

Ohio Department of Health • School and Adolescent Health

Health History

Student's name	Sex ☐ Male ☐ Female	Date of birth / /

Family Health History Please list allergies, heart problems, diabetes, cancer or other serious health conditions.

Father
Mother
Brothers and Sisters

Birth and Developmental History ☐ No unusual birth or developmental history

Did the mother have any unusual physical or emotional illness during this pregnancy? ☐ Yes ☐ No

Was infant born full term? ☐ Yes ☐ No Did the infant have any sickness or problems? ☐ Yes ☐ No

Briefly explain illness or problems.

____

How does the child's development compare to other children, such as his or her brothers/sisters or playmates?

☐ About the same ☐ Delayed ☐ Advanced

Student Health Conditions

☐ **YES,** my child receives regular medical/health care for the following conditions: ☐ **NO** medical conditions

☐ Allergies	☐ Diabetes	☐ Seizure disorder
☐ Asthma	☐ Depression	☐ Sickle cell anemia
☐ ADD/ADHD	☐ Ear problem/hearing difficulty	☐ Skin conditions
☐ Autism	☐ Emotional concerns	☐ Speech problems
☐ Behavior concerns	☐ Headaches	☐ Traumatic brain injury
☐ Birth/congenital malformations	☐ Heart problems	☐ Vision problems (glasses, contacts)
☐ Bone/muscle/joint problems	☐ Hemophilia	☐ Other ____________
☐ Blood problems	☐ Juvenile arthritis	☐ Other ____________
☐ Bowel/bladder problems	☐ Lead poisoning	☐ Other ____________
☐ Cancer	☐ Migraines	☐ Other ____________
☐ Cystic fibrosis	☐ Neuromuscular disorder	☐ Other ____________

Please explain any conditions above or any reasons for hospitalizations.

____

Please indicate any allergies your child may have.

Allergy type	Reaction	School restrictions or recommended actions
☐ Bee/Insect		
☐ Food		
☐ Medication		
☐ Other		

Health History continued

Please list any prescription and over the counter medication that your child takes on a regular basis.

Medication and dose	Time	Reason

Do any health and/or medical conditions require school restrictions, modifications, and/or intervention?

☐ Yes ☐ No If YES, please explain. ______________________________

Does the student require any special procedures and/or treatments for their health condition(s)?

☐ Yes ☐ No If YES, please explain. ______________________________

Please indicate any other information about your child's health or development that you think would be helpful for the school to know.

Form completed by	Relationship to student	Date
		/ /

Ohio Department of Health • School and Adolescent Health

Physical Examination

Student's name	Sex ☐ Male ☐ Female	Date of birth / /

Height	Weight	BMI percentile	BP

Screening Tests

Vision

Date performed / /

Distance Acuity	☐ R	☐ L
Muscle Balance	☐ Pass	☐ Fail
Stereopsis	☐ Pass	☐ Fail
Color	☐ Pass	☐ Fail
Child wears glasses?	☐ Yes	☐ No
Tested with glasses?	☐ Yes	☐ No
Referral made?	☐ Yes	☐ No

Hearing

Date performed / /

Pure Tone		
Right ear	☐ Pass	☐ Fail
Left ear	☐ Pass	☐ Fail
Child wears hearing aid?	☐ Yes	☐ No
Child under the care of a hearing specialist	☐ Yes	☐ No
Referral made?	☐ Yes	☐ No

Postural

Date performed / /

☐ No abnormality noted
☐ Screening not done
☐ Referral made

Comments

Speech/Language

Speech assessment completed	☐ Yes	☐ No
Child has no discernible speech problem	☐ Yes	☐ No
Speech evaluation recommended	☐ Yes	☐ No

Child has possible problem with ______

Lead Poisoning

☐ Date ______ Type ☐ C ☐ V Results______ µg/dL
☐ Date ______ Type ☐ C ☐ V Results______ µg/dL

Tuberculin Test

Date______ Type ______ Results______

Health History (Serious or chronic illnesses/injuries/surgeries)

Physical Examination

Date of most recent examination / /

☐ Essentially normal ☐ Abnormalities as follows

Is this child able to participate fully in:

Classroom and academic activities	☐ Yes	☐ No	Physical education classes	☐ Yes	☐ No
Competition athletics	☐ Yes	☐ No	Contact and collision sports	☐ Yes	☐ No

If limitations are advised, please specify

Does this child have any physical, developmental or behavioral issues that may affect his/her educational process?

HealthCare Provider's signature	Print name	Phone ( )
Address		Date / /
City	State	ZIP

HEA 4242 8/06

Ohio Department of Health • School and Adolescent Health

Oral Assessment

Student's name	Date of birth / /

The following services have been performed (please check all that apply)

- ☐ Examination
- ☐ Fluoride application
- ☐ Oral prophylaxis (cleaning)
- ☐ Prescription for fluoride supplement
- ☐ Orthodontic assessment
- ☐ Radiographs
- ☐ Dental sealant
- ☐ Treatment (restoration, pulp therapy)
- ☐ Other ______

The following oral hygiene instruction was provided (please check all that apply)

- ☐ Toothbrushing
- ☐ Flossing
- ☐ Dietary counseling
- ☐ Use of fluoride mouthrinse
- ☐ Other ______

The following statements are applicable (please check all that apply)

- ☐ All necessary preventive services have been performed. (Fluoride treatment, prophylaxis)
- ☐ No restorative services are required at this time.
- ☐ Further treatment is indicated.(See comments)
- ☐ Further appointments have been arranged. (Orthodontic, restorative)
- ☐ Routine recall visits recommended.

Comments

______

______

______

______

Dentist's signature	Print name	Phone ( )
Address		Date / /
City	State	ZIP

HEA 4243 8/06

STATE OF OHIO
LEGAL IMMUNIZATION EXEMPTION
Per OHIO STATUTE 3313.671 (Exemptions)

Religious,GoodCause,and Medical Exemption Form
Amended Substitute Senate Bill No.282. Ohio Revised Code
Sections 3313.671.Pat (3) and (4)

Section 3313.671, part (3): A pupil who presents a written statement of his parent or guardian in which the parents or guardian objects to the immunization for good cause, including religious convictions, is not required to be immunized.

Section 3313.671 part (4) : A child whose physicians certifies in writing that such immunizations against my disease is medically contraindicated is not required to be immunized against that disease. This section does not limit or impair the right of a board of education of a city,exempted village, or local school district to make and enforce rules to secure immunization against poliomyelitis, measles, mumps and rubella, diphtheria, pertussis, varicella, and tetanus of the pupils under its jurisdiction.

I understand that the immunization Law permits me to sign a waiver on my child taking the immunization.

I hereby object and request the school to waiver the immunization of my child against the following:

Dtap TD Polio MMR Hep B Varicella Meningococcal

Child's Name______________________

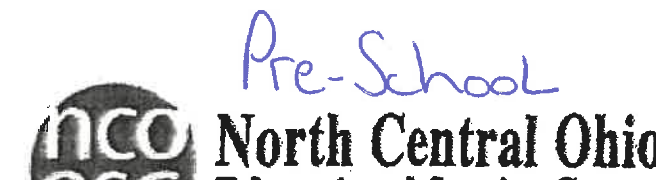
Religious: List name of denomination______________________

Good Cause: Please explain______________________________________

MedicalReason: You must have a signed statement from your physician stating the condition and attach it to this form.

I further understand that during the course of an outbreak of any of the aforementioned vaccine preventable diseases, that the student named here is subject to exclusion from school for the duration of the outbreak.
This action is necessary not only to protect this student, but the remainder of the students and faculty of the school.

Parent/Guardian Signature_______________________________ **Date**___________



State of Ohio Legal Immunizations Exemption

Per Ohio Statute 3313.671 (Exceptions)

Section 3313.671, Part (4) A pupil who presents a written statement of the pupil's parent or guardian in which the parent or guardian declines to have the pupil immunized for reasons of conscience, including religious convictions, is not required to be immunized.

Section 3313.671, Part (5) A child whose physician certifies in writing that such immunization against any disease is medically contraindicated is not required to be immunized against that disease.

I understand that the Immunization Law permits me to sign a waiver on my child taking the immunization.

I further understand that during the course of an outbreak of any of the vaccine preventable diseases mentioned below that the student named here is subject to exclusion from school for the duration of the outbreak.

I hereby object and request the school to waive the immunization of my child against the following (check all that apply):

- ☐ DTaP (Diphtheria, Pertussis, Tetanus)
- ■ Hepatitis A
- ☐ Influenza
- ☐ Meningitis
- ☐ Hepatitis B
- ☐ Hib (Haemophilus Influenzae B)
- ☐ Polio
- ☐ Varicella (Chickenpox)
- ☐ Rotavirus
- ☐ Pneumococcal Disease
- ☐ MMR (Measles, Mumps, Rubella)

___ Medical Reason: Must attach a signed statement from child's physician stating the related medical condition.

___ Religious Reason: Name of Denomination ______________________________

___ Good Cause: Please Explain ______________________________

____

____

Child's Name ______________________ Date ______________

Parent/Guardian Name ______________________________

Parent/Guardian Signature ______________________________