Colleton County SCHOOL DISTRICT
PREPARING EVERY CHILD TODAY FOR TOMORROW

Teacher:

Student Emergency Information Form

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

Home Address: _____

Please indicate any health conditions that require treatments, procedures, medications, or health monitoring for your student during the school day. Please list the physician treating your child as well:

Mother/Guardian: _____ Work Phone: _____ Cell Phone: _____ Home Phone: _____

Father/Guardian: _____ Work Phone: _____ Cell Phone: _____ Home Phone: _____

Emergency Contacts: Please list two contacts that will be called **ONLY** if you cannot be reached in an emergency.

Name: _____ Relationship: _____ Phone:

Name: _____ Relationship: _____ Phone: _____

The principal and/or school nurse may share health information with individuals who have responsibilities for my child. I authorize District officials to contact the person named on this form and authorize the named physician to render to my child whatever emergency treatment deemed necessary. If the physician, other persons named above, or parent cannot be reached, the District Officials may take whatever action they deem necessary for the health of my child. I will not hold the School District of Colleton County responsible for the emergency care and/or transportation of my child. I will keep the school informed of any changes on this form.

Signature of Parent/Guardian: _____ **Date:**

Consent for Treatment, Release of Information, and Reimbursement for Non-IEP Nursing Services by my signature below, I consent for Colleton County Schools to:

- provide Non-IEP Nursing services to my child;
- release and exchange the following information from my child's record to the Department of Health and Human Services (Medicaid Agency) for the purpose of billing for the Non-IEP Nursing services provided to my child – information about the service provided, my child's name, date of birth, Medicaid or health insurance number, gender, and my contact information;
- bill the Medicaid Agency for the Non-IEP Nursing services; and
- receive payment from the Medicaid Agency for the Non-IEP Nursing services that the District provides to my child.

I understand that:

- Medicaid reimbursement for Non-IEP Nursing services provided by the District will not affect any other Medicaid services for which my child is eligible.
- The District will continue to provide required Non-IEP Nursing services for my child at no cost to me even if I refuse to allow billing for services.
- Granting consent is voluntary on my part and may be revoked at any time. If I later revoke consent, that revocation is not retroactive (i.e., it does not negate an action that has occurred after the consent was given and before the con sent was revoked).
- The District will operate under the guidelines of the Family Educational Rights and Privacy Act (FERPA) to ensure confidentiality regarding my child's treatment and provision of Non-IEP Nursing services.

Student's Name: _____ Date: _____

Student's Date of Birth: _____ Student's Medicaid #: _____

Signature of Parent/Guardian: _____

SCDE 7.29.16

Colleton County SCHOOL DISTRICT

Physician and Parent School Asthma Management Plan

Student:	**DOB:**	**Phone:**
Physician:	**Physician Phone:**	

RESCUE: With Breathing Difficulties Give Rescue Medicine:

MEDICATION:	DOSE:

Observe student for twenty minutes after rescue medicine administration or until breathing difficulties are relieved. If student is still experiencing breathing difficulties after 20 minutes:

IT IS / IT IS NOT okay to repeat rescue treatment. Observe student for twenty minutes between treatments or until breathing difficulties are relieved. It is okay to repeat rescue treatment a total of _____ times to relieve breathing difficulties.

1. Puffs should be administered individually with 10-second breath hold, wait at least **60** seconds between puffs.
2. If students breathing difficulties are not relieved after the above maximal treatment, parents should be called to come pick-up child from school and notified of need for call to physician for urgent medical attention.

If more than one rescue treatment is ever required to relieve breathing difficulties or student *requires rescue treatment more than two times in one week, the parents should be notified of need to schedule physician office visit for poorly controlled asthma.*

If student is experiencing extreme shortness of breath or lips and fingernail beds are blue, Emergency Medical Services should be called and rescue albuterol treatments given until EMS arrives.

SICK PLAN: ***During Asthma Flare-ups scheduled rescue treatments are needed:***

For one week following an ER or physician office visit for an asthma flare-up or notification of sickness by parent: Administer _____puffs/ *of* _____ *every four hours and before PE or other strenuous activities. If student requires rescue treatment before four-hour treatment interval parents should be called to pick-up student and notified of need for physician visit.*

MEDICATION:	DOSE:

- It is the responsibility of student's parent/guardian to notify the school nurse of student's asthma flare-up or chest cold and the need for scheduled treatments
- After 48 hours on the above sick plan treatment, if the asthma symptoms do not improve or get worse, parents should be contacted with concerns. Some sick plans may extend in excess of one week
- If after one week on sick plan all asthma symptoms do not disappear parent should be notified of need to schedule a physician office visit for poorly controlled asthma.
- All ER visits for asthma flare-up should be followed by a Physician Office visit within 3 days. Unless contrary to ER physician's judgment, it is okay for child to attend school until follow-up visit

DAILY ASTHMA CONTROL PRESCRIBED FOR HOME

MEDICATION	DOSE	FREQUENCY

- Known Allergies and Asthma Triggers include:
- All asthmatics should avoid exposures to airway irritants like smoke, perfume, dust, air fragrances and high levels of ozone.

HEALTH ROOM GUIDELINES			
☐ **Student may carry the inhaler at school.** ☐ **Student also needs inhaler available for rescue in Health Room.**	☐ **Student should have inhaler in the Health Room for administration by nurse or designated district employee.**	**Student needs treatment with rescue inhaler prior to:** ☐ **Physical Education** ☐ **Recess** **Doses should be 4 hours apart.**	☐ **Student does not need treatment with rescue inhaler routinely except during asthma flare-up.**

SPACER RECOMMENDED: ____ YES ___ NOT REQUIRED

I AGREE WITH SCHOOL AND HOME ASTHMA MANAGEMENT PLAN. My child has my permission to use inhaler at school as described in plan. I agree to communication of changes in my child/guardian's asthma condition and management plans between my child/guardian's school, hospital and physicians. I, as the person responsible for my child/guardian's medical care, will be included/informed of communication regarding my child's medical care.

Guardian's Signature: _____ Date: _____

I have seen this child, authorize inhaler use at school in health room according to plan, and agree with plans for management of student's asthma at home and school.

Physician's Signature: _____ Date: _____

Colleton County SCHOOL DISTRICT
PREPARING EVERY CHILD TODAY FOR TOMORROW

Medical Health Services
COLLETON COUNTY SCHOOLS

MED-6 rev 8/2019
ANAPHYLAXIS AUTHORIZATION

ANAPHYLAXIS MEDICATION AUTHORIZATION

(Must be completed by parent/legal guardian and physician before medication can be accepted at school)

SCHOOL YEAR: _____

STUDENT NAME: _____ Date of Birth: _____

PARET/LEGAL GUARDIAN: _____

PHONE #1:	PHONE #2:

EMERGENCY CONTACTS:

NAME: _____ PHONE: _____

NAME: _____ PHONE: _____

PHYSICIAN'S NAME: _____ PHONE #: _____

CHILD IS SEVERELY ALLERGIC TO:

MEDICATION TO BE ADMINISTERED AT SCHOOL:

	MEDICATION	DOSE
	DIPHENHYDRAMINE	
	OTHER	

PHYSICIAN'S SPECIFIC INSTRUCTIONS FOR MEDICATION ADMINISTRATION:

STUDENT MUST CARRY MEDICATION: YES ☐ NO ☐ STUDENT IS ASTHMATIC: YES ☐ NO ☐

STUDENT IS AT HIGH RISK FOR SEVERE REACTION: YES ☐ NO ☐

STUDENT IS REQUIRED TO CARRY THIS MEDICATION ON THE BUS: YES ☐ NO ☐

CHILD'S FIRST SYMPTOMS MAY START AS: (CHECK ALL THAT APPLY)

- ☐ Itching and swelling of the lips, tongue, or mouth
- ☐ Itching and/or a sense of tightness in the throat, hoarseness, and hacking cough
- ☐ Hives, itchy rash, and/or swelling around the face or extremities
- ☐ Nausea, abdominal cramps, vomiting, and/or diarrhea
- ☐ Shortness of breath, repetitive coughing, and/or wheezing
- ☐ "Thready" pulse or passing o u t

STUDENT NAME: _____

THE SCHOOL DISTRICT WILL PROVIDE TRAINING FOR STAFF AT THE SCHOOL TO ASSIST YOUR CHILD IF NEEDED.

FIELD TRIPS:

- ☐ I will accompany my child on all field trips away from the school and assume responsibility for administering medication if needed.
- ☐ The student has permission from the physician to carry and self-administer the medication and will be responsible for having medication available for trips off campus.
- ☐ The teacher in charge of the field trip will additionally be trained and have responsibility for administering medication if needed.

BUS TRANSPORTATION:

- ☐ YES, THE BUS DRIVER NEEDS TO BE NOTIFIED
- ☐ NO, THE BUS DRIVER DOES NOT NEED TO BE NOTIFIED

PARENT/LEGAL GUARDIAN WILL PROVIDE ALL NECESSARY SUPPLIES/MEDICATION AND NOTIFY THE SCHOOL OF CHANGES IN CONDITION OR PRESCRIBED TREATMENT PLAN

I understand that all medication will be provided by me in the original container, clearly labeled with prescription information that lists my child's name. Permission is granted to the principal and/or school nurse to share this information with individuals who have responsibility for my child. I give the school permission to contact listed physician's office to request medical information concerning my child. I am aware of the expiration date and will replace medication before it expires. If the physician authorizes my child to carry his/her medication during the school day, I understand that I cannot hold the school district responsible for any adverse outcome of this action.

PARENT/LEGAL GUARDIAN SIGNATURE: _____ DATE: _____

I HAVE SEEN THIS CHILD AND AGREE WITH THE ABOVE TREATMENT:

PHYSICIAN'S SIGNATURE: _____ DATE: _____

BOTH AREAS MUST BE COMPLETED IF THE MEDICATION IS TO BE CARRIED AND SELF-ADMINSTERED

☐ THIS STUDENT IS TO SELF-ADMINISTER AND SELF-MONITOR THIS MEDICATION WHILE AT SCHOOL. TRAINING HAS BEEN COMPLETED BY THE PHYSICIAN AND THE STUDENT HAS DEMONSTRATED COMPETENCY IN SELF-MONITORING AND SELF-ADMINISTRATION OF THIS MEDICATION. MEDICATION MUST BE WITH STUDENT DURING CLASS TIME AND ANY SCHOOL SPONSORED ACTIVITY. THE PARENT IS AWARE THAT THEY CANNOT HOLD THE SCHOOL DISTRICT RESPONSIBLE FOR ANY ADVERSE OUTCOME OF THIS ACTION.

PARENT/LEGAL GUARDIAN SIGNATURE: _____ DATE: _____

PHYSICIAN'S SIGNATURE: _____ DATE: _____

PLEASE DO NOT HESITATE TO ADMINISTER MEDICATION OR CALL 911. ALERT EMS TO POSSIBLE ALLERGIC REACTION.

MED-3 rev 8-2019

THE SCHOOL DISTRICT OF COLLETON COUNTY

AUTHORIZATION FOR NON-PRESCRIPTION MEDICATION AT SCHOOL

(MUST BE SIGNED BY PARENT)

PLEASE PRINT *SCHOOL YEAR:* _____

STUDENT'S NAME: _____ BIRTH DATE: _____

LEGAL GUARDIAN: _____ DAYTIME PHONE: _____

NAME OF MEDICATION: _____

REASON FOR GIVEN MEDICATION AT SCHOOL. (PLEASE BE SPECIFIC): _____

AMOUNT OF MEDICATION TO BE GIVEN: _____

DATE TO ***START*** MEDICATION: _____ DATE TO ***STOP*** MEDICATION: _____

TIME OF DAY MEDICATION IS TO BE GIVEN: _____

EXPIRATION DATE OF MEDICATION: _____

POSSIBLE SIDE EFFECTS: _____

STUDENT'S PHYSICIAN: _____ PHONE #: _____

PARENTS: PLEASE READ CAREFULLY:

I understand that all medication will be provided by me in the original, new and sealed container, clearly labeled with my child's name. *I will notify the school if the medication is discontinued or the dosage has been changed.* Permission is granted to the principal and/or school nurse to share this information with individuals who have responsibility for my child. The first dose will be given at home so that I can monitor adverse reactions. I give the school nurse my permission to contact the physician's office to request medical information concerning my child. I am responsible for replacing medication before the expiration date.

_____ _____

Legal Guardian Date

PLEASE NOTE:

A SEPARATE PERMISSION FORM IS REQUIRED FOR EACH MEDICATION TO BE GIVEN.

PARENTS ARE RESPONSIBLE FOR NOTING THE EXPIRATION DATE OF ALL MEDICATION. EXPIRED MEDICATION WILL NOT BE GIVEN AT SCHOOL.

ANY MEDICATION NOT PICKED UP BY THE LAST DAY OF SCHOOL WILL BE DESTROYED ACCORDING TO SCHOOL DISTRICT GUIDELINES.

ANY OVER-THE-COUNTER MEDICATION GIVEN EVERY DAY FOR 10 CONSECUTIVE DAYS MUST HAVE PHYSICIAN'S AUTHORIZATION.

MED-1 rev 8-2019

THE SCHOOL DISTRICT OF COLLETON COUNTY

AUTHORIZATION FOR PRESCRIPTION MEDICATION AT SCHOOL

(MUST BE SIGNED BY PARENT AND PHYSICIAN)

PLEASE PRINT *SCHOOL YEAR:* _____

STUDENT'S NAME: _____ DATE OF BIRTH: _____

LEGAL GUARDIAN: _____ DAYTIME PHONE: _____

NAME OF MEDICATION: _____ ROUTE: _____

REASON FOR GIVEN MEDICATION AT SCHOOL. (PLEASE BE SPECIFIC): _____

_____

AMOUNT OF MEDICATION TO BE GIVEN: _____

TIME OF DAY MEDICATION IS TO BE GIVEN AT SCHOOL: _____

EXPIRATION DATE OF MEDICATION: _____

DATE TO START MEDICATION: _____

DATE TO STOP MEDICATION: _____

POSSIBLE SIDE EFFECTS: _____

_____

PHYSICIAN'S SIGNATURE: _____ DATE: _____

OFFICE PHONE #: _____

PARENTS PLEASE READ CAREFULLY:

I understand that all medication will be provided by me in the original container, clearly labeled with my child's name. *I will notify the school if the medication is discontinued or the dosage has been changed.* Permission is granted to the principal and/or school nurse to share this information with individuals who have responsibility for my child. The first dose will be given at home so that I can monitor adverse reactions. I give the school nurse my permission to contact the above named Physician's office to request medical information concerning my child. I am responsible for replacing medication before the expiration date.

LEGAL GUARDIAN'S SIGNATURE: _____ DATE: _____