# School Nurse Orientation Manual

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Phillips Heartstart FRx SN#: _______________
Battery Expiration: ________________
Adult Defibrillation Pads Expiration: ________________

<table>
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<th>Gloves</th>
<th>Razor</th>
<th>Scissors</th>
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</table>
AED Protocols

Name of School

Subject: Automated External Defibrillator

Date:

Purpose: The automated external defibrillator (AED) shall be obtained and maintained at ________________ for the purpose of rapid response to a cardiac arrest situation within the school’s geographic perimeter or at selected school-sponsored events. Combined with bystander CPR, this medical device becomes a key element in the chain of survival.

Location of the AED:

Usage: Use of the AED will be delegated to the personnel who have attended the AED training and have successfully passed the course, received the Heartsaver AED certification card, and as designated by the school administration. Activation of the Team will be by radio and or intercom overhead page.

Education/Training: Designated team members will have at least annual CPR/AED review and drill with mandatory biannual recertification. Awareness information will be included in student/staff handbooks distributed at the beginning of each school year and covered during staff orientation by nurse when reviewing Blood borne pathogen. (See attached Heartsaver/AED Course Roster of Certified Attendance)

Equipment maintenance: The AED and 1st Responder kit will be checked and logged regularly by the program coordinator or an appointed designee. Maintenance will be per manufacturer’s recommendations as to battery/pads replacement.

Equipment List: The following equipment was delivered new to the program coordinator on ________________ and will be subject to the above referenced maintenance checks- Phillips Heartstart Defibrillator(1), Red carrying case(1), First Responder kit attached to carrying case in red pouch(1) including contents:(vinyl gloves-2pair, reusable mouth barrier-1, disposable safety razor-1, disposable antimicrobial wipe-1, trauma scissors-1 pair, towel-1).

Signature:________________________________   Date: _______________________


Back to School Checklist

Connecting with School Staff
☐ Meet with the principal.
☐ Communicate with school staff regarding the school nurse's role and rules for the health room.
☐ Identify custodial staff. Find out how to contact a custodian when needed.
☐ Contact school psychologist, introduce you and to find out about special education students who will need hearing and vision for upcoming IEP's.
☐ Identify the contact for the Special Education department in the building.
☐ Identify the physical therapist and occupational therapist for your school. What days are they scheduled to work in your school? How can they be contacted?
☐ Find out who the 504 coordinator is.

Planning
☐ Ask your supervisor/principal where you get office supplies (note pads, pencils, copier paper). You can always call me.
☐ Obtain class lists/bus schedules as appropriate.
☐ Establish lunch schedules for you.
☐ Prepare the health room with posters, educational materials and books for students.
☐ Make sure the health room is stocked with supplies.
☐ Prepare an emergency kit for the health room.
☐ Determine when and where school team meetings meet (e.g. SIT team meetings, Individual Education Plan (IEP) teams). If the student has a health need, you may be invited to attend the meeting.
☐ Familiarize yourself with the substitute system. Currently we will have 3 subs. If you know in advance that you will be out, please let me know so I can arrange a sub for your school.
☐ Familiarize yourself with the forms and procedures for students to be allowed to come to the health room and to return to class.
☐ Familiarize yourself with the mail system (inner office mail)
☐ Determine health room policies concerning early dismissals, passes, calling parents for dismissal,
☐ Determine how to locate a student in class and how to summon a student to the health room.
☐ Determine how to get information to parents (newsletter, note home, etc.).

Documentation and Review
☐ Familiarize yourself with all documents/forms and student health records (electronic or hard copy) that are used.
☐ Review immunization status of new students.
☐ Review and prepare for all medication/treatment orders received to include exp.date and picture of student. Review emergency information from parents.
☐ Develop an emergency plan for students with health needs (include classroom emergency kit).
☐ Review emergency plans with all school staff involved (don't forget bus drivers/cafeteria staff).
☐ Review disaster plans. Check AED monthly and document.
☐ Prepare student records.
☐ Prepare to collect data from parents if student on special diet, allergies, asthma, diabetes etc.
☐ Prepare letter or school newsletter article for parents.
☐ Review and note deadlines for any information that has to be submitted to administration, supervisors (e.g. immunization data, screening results from vision and hearing)
☐ Read student handbook/faculty handbook.
☐ Locate and familiarize yourself with any guidelines or procedures for the school health program, first aid, and emergency care.
Training
☐ Set date and provide BBP training for faculty and staff.
☐ Provide staff training for medication administration/CPR/first aid.

If you are assigned to more than one school:
☐ Determine work schedule and give to secretary, principal, health assistants, and supervisor -- i.e.,
days you will be in the school(s).
☐ Exchange telephone numbers with health room/school staff.
Community Blood Bank (CBB)
Protocols

(1) Distribute brochure (attached) for educational purposes at least one week in
advance. Provide an overview and discussion through PE classes or another
avenue identified by the school to discuss the educational brochure and
information about the CBB.

(2) Establish a contact person at each school.

(3) Establish the number of persons needed for each blood drive, including school
faculty and CBB staff. Currently the CBB operates on a “dash rate” or ratio of 1
to .8, indicating that there would be an average of 12-15 CBB staff persons
present at each school drive. CBB is requesting a minimum of one school faculty
to staff member to redirect students back to class once they have been released.
   a. Staff placements include:
      i. Registration
      ii. Drawing Station
      iii. Mash Unit/Recovery Station
      iv. Snack Station (Recovery)

(4) CBB staff stay on-site and with all students until all have been cleared to return to
school.

(5) School nurse will be on-site throughout the entire drive.

(6) Parental consent for all students is checked at registration and required to
participate in donation through age 18.

(7) CBB will provide Certificate of Insurance to Dr. Cindy Lane’s office for district
records.
Ordering supplies:

1. School health for nursing supplies. Email me what you need without the catalog number and I will place the order,
2. For quick supplies, I use Staples. Again, just email me what you need.
3. Supplies from the Library at the Ed Center: thermometer probes, batteries, equipment such as hearing, vision, otoscope, pulse oximeter, b/p cuff adult and/or child and extra large cuff.
4. Nursing forms
5. Biohazard containers. Once the container is full, bring the full one to the Ed Center. A red container is located in the mail room for disposal. You can pick up a new container from the library here at the Ed Center.
6. If your equipment does not work, please let me know so I can send a replacement. All nurses must have a stethoscope, working pulse oximeter, b/p cuff as part of your emergency equipment. Glucose tablets will also be available in the library for students that have diabetes (part of the emergency kit) and also Peak flow meter mouth pieces will be kept at the library.
7. Each nurse will get a peak flow meter and should only to be used for students that have specific orders from the doctor as part of their action plan

Web IZ forms should be included in the enrollment packet. If form is signed, enter date signed into silk under miscellaneous. Once you enter this section, scroll down to the bottom and there will be a health box. Here is where you check if there is an immunization alert, physical alert, IHP, date of Web IZ form.

If you want to create a report from silk go to the report section. Then look for health and under health you will find compliance letters, reports to print out for immunization alerts etc.

On the KCKPS.org web page, under parents, you will find a student health section. Under this section you will find the special dietary forms that must be completed by the parent and the doctor if there is a special diet.

Any memo and/or letter that needs to be sent to a parent regarding any outbreak and /or illnesses must be approved before sending. You can email me the memo to be reviewed by David Smith.
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Revised 08/4/2014
**Breakfast**

### Drinks
- 1% Milk=11g
- Skim milk=11g
- Apple juice=13g
- Apple-cherry juice=13g
- Dragon punch=13g (veggie blend)
- Grape juice=21g
- Orange juice=13g
- Orange-pineapple juice=14g
- Pineapple juice=15g
- Wango Mango juice=13g (veggie blend)

### Fruit
- Apple halves=11g
- Apple=15g
- Applesauce=22g
- Mott's Healthy Harvest Strawberry applesauce=13g
- Banana=19g
- Grapes=21g
- Orange wedges/smiles=21g
- Pear=20g

### Other
- Breakfast Bar=39g
- Breakfast burrito with salsa=29g
- Breakfast pizza=22g
- Breakfast Slider=22g
- Hot pocket, egg/turkey/sausage=14g
- Sunrise flat bread pizza=20g

### Cereal
- Apple Jack's =18g
- Chocolate mini-wheats=23g
- Cinnamon Toast Crunch cereal=21g
- Rice Krispie Apple Cinnamon Cereal Bar=24g

### Grains
- Apple muffin=24g
- Bagel-ful, cinnamon (Bagel with cream cheese)=32g
- Banana Muffin, Sky Blue Bakery 66% Wheat Simply Banana, 1.6 oz=23g; 3.2 oz=45g
- Banana CC Bar=
- Banana nut bread=44g
- Blueberry mini-loaf=27g
- Cinnamon goldfish=19g
- Cinnamon Roll=43g
- French toast, homestyle=27g
- French toast, chocolate chip=35g
- Fruit Churro=12g

### Granola/NutraGrain Bars
- Graham Crackers: Chocolate=18g; Honey & Oat=18g; Strawberry=18g; Vanilla=18g
- Brown sugar granola bar=24g

### Pancakes
- Blueberry=31g
- Blueberry=

### Waffles
- Mini maple=35g
- Blueberry=

### Zucchini bread=43g
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<td>Soup Beef Vegetable</td>
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<td>Spaghetti 41g &amp; Meat sauce = 12g</td>
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<td>Chicken, Tangerine</td>
<td>25g</td>
<td>Tex-Mex Pasta Bake</td>
<td>40g</td>
</tr>
<tr>
<td>Chipotle Bowl, Chicken</td>
<td>24.5g</td>
<td>Tuna only Plate</td>
<td>2g</td>
</tr>
<tr>
<td>Chipotle Bowl, Pork</td>
<td>21g</td>
<td>Turkey &amp; Cheese Wrap</td>
<td>34g</td>
</tr>
<tr>
<td>Corn Dog</td>
<td>19g</td>
<td>Turkey Pot Pie</td>
<td>20g E</td>
</tr>
<tr>
<td>Corn Dogs, Mini</td>
<td>31g</td>
<td>Veggie Burger on Bun</td>
<td>28g</td>
</tr>
<tr>
<td>Cuban Sandwich on Pretzel Bread</td>
<td>30g</td>
<td>Veggie Wrap</td>
<td>32g</td>
</tr>
<tr>
<td>Deli Sandwich or Wrap</td>
<td>34g</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enchilada cheese 1 or 2</td>
<td>14g/28g</td>
<td></td>
<td></td>
</tr>
<tr>
<td>French Toast Sticks</td>
<td>31g</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frito Pie w chips</td>
<td>25g</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gold Fish Turkey &amp; cheese Sanswich</td>
<td>22g</td>
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<tr>
<td>Grilled Cheese WG</td>
<td>34g</td>
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<tr>
<td>Hamburger on WG Bun</td>
<td>25g</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hotdog on WG Bun</td>
<td>20g E</td>
<td></td>
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<tr>
<td>Hummus Wrap</td>
<td>43g</td>
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<td>Hummus=28 on Pita=17g</td>
<td></td>
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</tr>
<tr>
<td>Italian sub</td>
<td>20g E</td>
<td></td>
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</tr>
<tr>
<td>Lasagna cheese</td>
<td>29g</td>
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<td></td>
</tr>
<tr>
<td>Lasagna Meat</td>
<td>25g</td>
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<tr>
<td>Lasagna Vegetarian Roll</td>
<td>29g</td>
<td></td>
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<tr>
<td>Macaroni &amp; Cheese</td>
<td>20g E</td>
<td></td>
<td></td>
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<tr>
<td>Marinara Sauce</td>
<td>4g</td>
<td></td>
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<tr>
<td>Max Sticks w Marinara Sauce</td>
<td>36g</td>
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<tr>
<td>Meatball Sandwich</td>
<td>22g</td>
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</tr>
<tr>
<td>Meatloaf, homestyle</td>
<td>5.5g</td>
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<tr>
<td>Mini Pan Pizza</td>
<td>32g</td>
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<td>Mozzarella Cheese Sticks</td>
<td>52g</td>
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<tr>
<td>Nachos, cheesy</td>
<td>25g</td>
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<tr>
<td>Nachos, Macho</td>
<td>35.6g</td>
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<tr>
<td>Sides</td>
<td>Carbohydrates (g)</td>
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<tr>
<td>-------------------------------------------</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Baked Beans</td>
<td>29</td>
<td></td>
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<tr>
<td>Black Bean Salsa</td>
<td>19</td>
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<tr>
<td>Broccoli &amp; Tomatoes</td>
<td>4</td>
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<tr>
<td>Broccoli w Cheese</td>
<td>7</td>
<td></td>
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<tr>
<td>Broccoli/Cauliflower w Cheese</td>
<td>7</td>
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<tr>
<td>Carrots, 2 oz. baby carrots</td>
<td>5</td>
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<tr>
<td>Carrots, glazed</td>
<td>14</td>
<td></td>
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</tr>
<tr>
<td>Celery</td>
<td>1</td>
<td></td>
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</tr>
<tr>
<td>Chips</td>
<td>19</td>
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<tr>
<td>Chips, Sun Chips</td>
<td>18</td>
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<td>Coleslaw, fruited</td>
<td>7</td>
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<tr>
<td>Corn Cobbette</td>
<td>19</td>
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<td>Corn, steamed</td>
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<td>Corn, Whole Kernel</td>
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<td>Country Style Vegetables</td>
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<tr>
<td>Cucumber &amp; Carrot Chips</td>
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<td>Fresh Veggies</td>
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<tr>
<td>Fries, Confetti</td>
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<td>Fries, Curly</td>
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<td>Garden Romaine salad</td>
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<td>Garden Salad</td>
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<td>Green Beans</td>
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<td>Green Beans, Toasted Onion</td>
<td>24</td>
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<td>Mixed Greens</td>
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<tr>
<td>Potato, Buffalo Slices</td>
<td>28</td>
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<td>Potato, Tator Gems</td>
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<td>Potatoes, Augratin</td>
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<td>Potatoes, mashed</td>
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<td>Potatoes, Skillet</td>
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<td>Potatoes: Oval Hashbrowns</td>
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<td>Ranch Dressing, FF</td>
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<td>Rice, Santa Fe</td>
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<td>Sweet Potato Tots</td>
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<td>Sweet Potatoe, 1/2 baked</td>
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<tr>
<td>Zucchini &amp; Pepper Strips</td>
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<tr>
<td>Fruit</td>
<td>Carbs</td>
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</tr>
<tr>
<td>Apple Wedges</td>
<td>11g</td>
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<tr>
<td>Applesauce</td>
<td>15g</td>
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<tr>
<td>Fresh Fruit Bowl</td>
<td>17g</td>
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<td>Frozen Fruit Treat</td>
<td>18g</td>
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<tr>
<td>Grapes, fresh</td>
<td>21g</td>
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<tr>
<td>Jello, Fruited</td>
<td>17g</td>
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<tr>
<td>Kiwi &amp; Berries</td>
<td>17g</td>
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<td>Kiwi &amp; Strawberries</td>
<td>17g</td>
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<tr>
<td>Mango Mixed Fruit</td>
<td>18g</td>
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<td>Mixed Berry &amp; Lemon fruit Treat</td>
<td>18g</td>
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<tr>
<td>Peaches, Sliced</td>
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<td>Pear, fresh</td>
<td>15g</td>
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<td>Pears</td>
<td>15g</td>
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<td>Pears &amp; cherries</td>
<td>19g</td>
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<tr>
<td>Pineapple &amp; Oranges</td>
<td>18g</td>
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<tr>
<td>Strawberry * Mango</td>
<td>22g</td>
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</tr>
<tr>
<td>Strawberry Cup</td>
<td>22g</td>
<td></td>
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<td>Strawberry Frozen Fruit Treat</td>
<td>18g</td>
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<td>Tropical Mixed Fruit</td>
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<td>Mango Sherbet</td>
<td>26g</td>
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<tr>
<td>Syrup</td>
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</tr>
<tr>
<td>Apple Cider</td>
<td>15g</td>
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</tr>
<tr>
<td>Drinks</td>
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<tr>
<td>-------------</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Dragon Punch</td>
<td>13g</td>
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<td></td>
</tr>
<tr>
<td>Orange Juice</td>
<td>13g</td>
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<td></td>
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</tr>
<tr>
<td>Bread</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breadstick</td>
<td>13g</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rip Breadstick</td>
<td>13g</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Roll</td>
<td>30g</td>
<td></td>
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</tr>
</tbody>
</table>
PARENT/GUARDIAN TO COMPLETE

Date:___________________     School year:______________________

Student Name:_________________________ Date of Birth:_______ Grade: _____

Medical condition: Type 1 Diabetes  Type 2 Diabetes

Primary school person responsible for care: ________________________________

Secondary school person to provide care: ________________________________

Alternate school person(s) _____________________________________________
_____________________________________________________________________
_____________________________________________________________________

Additional school persons trained to recognize and respond to low BG
Bus driver       Gym teacher
Other (Name and Title):_________________________________________________
_____________________________________________________________________
_____________________________________________________________________

My diabetes health care provider is:_________________________ Phone number___________

Medication

- Insulin pen: Product Name (Manufacturer)  Luxura  Humalog Disposable
  - Novolog JR  Novolog Flexpen
- Type of insulin: Humalog  NovoLog  Apidra
- Type of Insulin Pump: Medtronic/Minimed  Cozmo  Animas  Omnipod

Parents are responsible for communicating the correct dose of insulin as well as any change in the dose of insulin.
### Student Abilities/Skills

<table>
<thead>
<tr>
<th>Task</th>
<th>Needs Assistance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Count carbohydrates</td>
<td>Yes</td>
</tr>
<tr>
<td>Bolus correct amount for carbohydrates consumed</td>
<td>Yes</td>
</tr>
<tr>
<td>Calculate and administer correction bolus</td>
<td>Yes</td>
</tr>
<tr>
<td>Give insulin by injection / insulin pen (circle one)</td>
<td>Yes</td>
</tr>
<tr>
<td>Enter blood glucose into pump</td>
<td>Yes</td>
</tr>
<tr>
<td>Suspend/resume insulin delivery in pump</td>
<td>Yes</td>
</tr>
<tr>
<td>Disconnect/reconnect pump</td>
<td>Yes</td>
</tr>
<tr>
<td>Prepare reservoir and tubing for pump</td>
<td>Yes</td>
</tr>
<tr>
<td>Insert infusion set for pump</td>
<td>Yes</td>
</tr>
<tr>
<td>Troubleshoot alarms and malfunctions in pump</td>
<td>Yes</td>
</tr>
<tr>
<td>Give insulin by injection if indicated (pumpers)</td>
<td>Yes</td>
</tr>
</tbody>
</table>

### Blood Glucose (BG) Testing

- **Target Range:** __________________________  Blood glucose meter used_________________
- **Usual times to test BG:** _______________________________________________________
- **Additional times to test BG:**
  - Before physical activity
  - After physical activity
  - When student has symptoms of high BG (hyperglycemia)
  - When student has symptoms of low BG (hypoglycemia)
  - Before student boards bus at end of school day
  - Other: _______________________________________________________________________

- **Can student perform own blood glucose testing?** Yes No
- **Where will testing occur?**  Classroom Health Room Main Office
  - Other_____________________

- **How will parent/guardian be notified of BG values obtained at school?**
  - Daily phone call  Daily written communication  Other_____________________

- **Symptoms of Hypoglycemia**

- **Treatment for Hypoglycemia**

- **Symptoms of Hyperglycemia**

- **Treatment for hyperglycemia**

*If student experiences hypoglycemia or hyperglycemia for 3-5 days in a row, please contact the parent/guardian to make appropriate changes in insulin dosages.*
Food

- Fast-acting carbohydrates such as ____________________________ are required to treat a low BG or to prevent a low BG (by giving to the student prior to vigorous physical activity). These will be kept in ____________________________.

- Food service personnel need to provide the serving size of items and nutritional information of foods included on the school menu.

- Instructions for when food is provided to a class on special occasions (i.e. birthday party, holiday event): __________________________________________________________

Physical Activity Guidelines

- Physical activity usually **lowers** blood glucose. The drop in blood glucose may be immediate or delayed as much as 12-24 hours.

- The child will need fast-acting carbohydrates **without dosing insulin** for every 30 minutes of vigorous physical activity. This amount of carbohydrate may need to be adjusted later after seeing the effect on blood glucose.

- Do **not** give a high blood glucose correction bolus within 1 hour of vigorous or prolonged activity.

Field Trips

School personnel designated to provide/supervise diabetes care on field trip(s):

______________________________________________________________________________

______________________________________________________________________________

Additional information to assist in student’s care of diabetes at school:

______________________________________________________________________________

______________________________________________________________________________
Supplies to be kept at School

Blood glucose meter and test strips
Lancet device and lancets
Blood/Urine ketone strips
Insulin vial or cartridge
Insulin syringes
Insulin pen and pen needles
Alcohol wipes
Supply of fast-acting carbohydrate __________________________

School personnel who will notify parent when supplies are getting low:
______________________________________________________________________________

______________________________________________________________________________

Contact Information

Mother/Guardian ________________________________________________________________

Telephone:  Home ____________  Work ____________  Cell _______________

Father/Guardian_______________________________________________________________

Telephone:  Home ____________  Work ____________  Cell _______________

Other Emergency Contacts:
Name ________________________  Relationship ________________________________

Telephone:  Home ____________  Work ____________  Cell _______________
Parental consent for management of diabetes at school

We (I), the undersigned, the parent/guardian of the above named pupil, request that the above specialized physical healthcare services for the management of diabetes in the school be administered to my child in accordance with the state laws and regulations. In addition, I agree to:

1. Provide the necessary supplies and equipment
2. Notify the school nurse if there is a change in student’s health status
3. Notify the school nurse immediately for any change in insulin dosages

I authorize the school nurse to communicate with the healthcare provider when necessary.

________________________________________________________________________    ________________________
Student’s Parent/Guardian                   Date

________________________________________________________________________    ________________________
School Nurse or designated personnel                   Date
Escuelas Públicas de Kansas City Kansas

PARA SER LLENADO POR EL PADRE O TUTOR

Fecha:_____________ Año Escolar:________________________________________

Nombre del Estudiante:________________________ Fecha de Nacimiento:__________ Grado:_______

Condición Médica: □ Diabetes Tipo 1 □ Diabetes Tipo 2

Persona responsable del cuidado en la escuela primaria:______________________________

Persona que proveerá cuidado en la escuela secundaria:______________________________

Persona(s) en la escuela alternativa:_______________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

Personas adicionales en la escuela entrenadas para reconocer y responder a una baja en la glucosa de la sangre (BG)

□ Chofer del camión □ Maestro(a) de Educación Física

□ Otro (Nombre y Título):________________________________________________________________

____________________________________________________________________________________

Mi proveedor de salud para la diabetes es:________________________ Número de teléfono___________

Medicamento

▪ Pluma con insulina: Nombre del producto (Fabricante) □ Luxura □ Humalog Desechable
  □ Novolog JR □ Novolog Flexpen

▪ Tipo de insulina: □ Humalog □ NovoLog □ Apidra

▪ Tipo de bomba de insulina: □ Medtronic/Minimed □ Cozmo □ Animas □ Omnipod

Los padres de familia son responsables de comunicar la dosis correcta de insulina, así como también cualquier cambio en la dosis de insulina.
Escuelas Públicas de Kansas City Kansas

Aptitudes/Habilidades del Estudiante

Cuenta carbohidratos □ Sí □ No Na
Cantidad correcta de carbohidratos consumidos □ Sí □ No Na
Calcula y administra el medicamento correcto □ Sí □ No Na
Se pone insulina en inyección/insulina en pompa (encierre uno) □ Sí □ No Na
Introduce la glucosa de la sangre con la bomba □ Sí □ No Na
Suspende/reanuda la administración de insulina en la bomba □ Sí □ No Na
Desconecta/reconecta la bomba □ Sí □ No Na
Prepara el depósito y la tubería de la bomba □ Sí □ No Na
Inserta el equipo de infusión para la bomba □ Sí □ No Na
Soluciona problemas de alarmas y malfuniones de la bomba □ Sí □ No Na
Pone insulina con inyección si está indicado (autobombas) □ Sí □ No Na

Prueba de Glucosa en la Sangre (BG)

Resultados:_________________________
Prueba que usa para medir la glucosa en la sangre _______________
Horarios habituales para medir BG_____________________________________
Horas adicionales para medir BG:
□ Antes de una actividad física  □ Después de una actividad física
□ Cuando el estudiante tiene síntomas altos de BG (hiperglucemia)
□ Cuando el estudiante tiene síntomas bajos de BG (hipoglucemia)
□ Antes de que el estudiante aborde el camión al final del día escolar
□ Otro:__________________________________________________________

¿Puede el estudiante hacerse su propia prueba de glucosa en la sangre? □ Sí □ No
¿Dónde se harán las pruebas? □ Salón de clases □ Oficina de la enfermera
□ Oficina de la escuela □ Otro____________________
¿Cómo será notificado el padre/guardián de los resultados obtenidos de BG en la escuela?
□ Llamada diaria □ Comunicación por escrito a diario □ Otro________________
Síntomas de Hipoglucemia__________________________________________________________
Tratamiento para Hipoglucemia__________________________________________________________
Síntomas de Hiperglucemia__________________________________________________________
Tratamiento para Hiperglucemia__________________________________________________________

Si el estudiante tiene hipogluemia o hiperglucemia por 3-5 días seguidos, por favor póngase en contacto con el padre/guardián para hacer los cambios adecuados en las dosis de insulina.
Escuelas Públicas de Kansas City Kansas

Alimentos

- Los carbohidratos de acción rápida tales como______________________ se requieren para tratar una baja BG o para evitar una baja BG (dándoselo al estudiante antes de la actividad vigorosa). Estos se guardan en:____________________________________________________________________________________________________.

- El personal de servicios de alimentos necesita proporcionar el tamaño de la porción de los alimentos, y la información nutricional de los alimentos incluidos en el menú de la escuela.

- Las instrucciones para cuando se proporcionan los alimentos a una clase en ocasiones especiales (por ejem: una fiesta de cumpleaños o un evento festivo):________________________ ________________________________

Guías Para Una Actividad Física

- La actividad física usualmente baja la glucosa en la sangre. La bajada de la glucosa en la sangre puede ser de inmediato o retrasarse tanto como 12-24 horas.

- El niño necesitará carbohidratos de acción-rápida sin poner insulina por cada 30 minutos de actividad física rigurosa. Esta cantidad de carbohidratos puede que sea necesario ajustarlo después de ver el efecto de la glucosa en la sangre.

- No dé una corrección de medicina alta para la glucosa en la sangre dentro de 1 hora de actividad vigurosa o prolongada.

Excursiones

Personal escolar asignado para proveer/supervisar el cuidado de la diabetes en la(s) excursión(es):

____________________________________________________________________________________
____________________________________________________________________________________

Información adicional para asistir en la escuela al estudiante en el cuidado de la diabetes:

____________________________________________________________________________________
____________________________________________________________________________________

____________________________________________________________________________________
Escuelas Públicas de Kansas City Kansas

Utensilios médicos para mantener en la escuela

☐ Medidor y tiras para medir la glucosa en la sangre
☐ Dispositivo de lanceta y lancetas
☐ Tiritas para prueba de sangre/orina
☐ Frasco o cartucho de insulina
☐ Jeringas para la insulina
☐ Pluma para la insulina y las agujas de las plumas
☐ Provisión de carbohidratos de acción rápida
☐ Otro_______________________________

Personal de la escuela que le notificará al padre de familia cuando los utensilios se estén terminando:
____________________________________________________________________________________
____________________________________________________________________________________

Información de contacto

Madre/Tutor de Familia______________________________________________________________
Teléfono: Hogar______________ Trabajo______________ Cell______________

Padre/Tutor de Familia______________________________________________________________
Teléfono: Hogar______________ Trabajo______________ Cell______________

Otros Contactos de Emergencia:

Nombre______________________________ Parestesco______________________________
Teléfono: Hogar______________ Trabajo______________ Cell______________
Escuelas Públicas de Kansas City Kansas

Consentimiento de los padres de familia para el manejo de la diabetes en la escuela

Nosotros (yo), el que firma abajo, el padre/guardian del alumno nombrado arriba, solicito de los servicios mencionados de salud física especializados, para que el tratamiento de la diabetes en la escuela pueda ser administrado a mi hijo de acuerdo con las leyes y regulaciones estatales. Además estoy de acuerdo a:

1. Proporcionar los medicamentos y el equipo necesario

2. Notificar a la enfermera de la escuela si hay algún cambio en el estado de la salud del estudiante.

3. Notificar a la enfermera de la escuela inmediatamente de algún cambio de la dosis de insulina.

Yo autorizo a la enfermera de la escuela a comunicarse con el proveedor de salud cuando sea necesario.

__________________________________________  ____________
Padre\Tutor del Estudiante                     Fecha

__________________________________________  ____________
Enfermera de la escuela o personal designado  Fecha
Health Services
Instruction Department

End of Year Reminder
Date: ____________________

Dear Parents:

[Name] will have medication left over after the last day of school. All controlled medications must be picked up from the nurse’s office by a parent or guardian by the last day of school at 2:30. Children cannot be responsible for transporting their prescription medication home. You may wish to take home your child’s medication anytime during school hours this week or the school office will be open from [time] Saturday, [date], Monday, [date], and Tuesday, [date], for anyone who needs to pick up the medication. All medication will be discarded after [date].

A Medication Permit/Physician’s Orders is attached for those parents who wish to have their physician’s signature available by the first day of school. I hope this will be helpful to you. Have a great summer!!

School Nurse

BISD Form IX C, 6/02
Fecha ____________________

Estimados Padres;

________________________ tendrá residuos de medicamentos después del último día de escuela. Todos aquellos medicamentos controlados o recetados deberán ser recogidos en la oficina de la enfermera por el padre o tutor en el último día de escuela a las 2:30 p.m. Los niños no pueden ser responsables de transportar sus medicamentos recetados a la casa. Usted también podrá llevarse los medicamentos de su hijo(a) esta semana durante horas de clase. De otra manera, la oficina de la escuela estará abierta el Sábado desde ______________, Lunes, ______________, y Martes ______________ para aquellas personas que ______________ para ______________ necesiten recoger medicamentos. Todos los medicamentos serán desechados después del ______________.

Le estoy incluyendo una Forma de Permiso para Medicamentos, para aquellos padres de desean tener la firma de su médico disponible en el primer día de clases. Espero que esto les sea de ayuda. ¡¡¡Disfruten el verano!!!

Enfermera Escolar

BISD SP Form IX C, 7/07
Eye Injury Notice to Parent

Date: ________________

____________________ received an injury to the _________________ eye at school today at ______________. He/She was treated and observed in the health room. We suggest that you call your doctor for instructions if your child develops any of the following symptoms: red eyeball, double vision or sharp pain in the eye.

Comments:

School: __________________________  Signed: __________________________

Phone: __________________________  Position: __________________________

Principal Notified: _______________

USD 500
Kansas City, Kansas Public Schools

N005
USD 500
Kansas City, Kansas Public Schools

Head Injury Notice to Parent

Date: ___________________

___________ received a head bump at school today at _______. He/She was

Student's name

treated and observed in the health room. We suggest that you call your doctor for instructions if

your child develops any of the following symptoms: headache, nausea, vomiting, dizziness,

unusual drowsiness, vision problems, mental confusion or disorientation.

Comments:

School: ___________________ Signed: ___________________

Phone: ___________________ Position: ___________________

Principal Notified: ___________________
Dear Parent,

[Image of a bandage]

Your student ______________________ came to the health office today at ____________________ expressing the following complaint:

<p>| | | | | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>allergies</td>
<td>9.</td>
<td>headache</td>
<td>17.</td>
<td>stomach ache</td>
<td>25.</td>
<td>Fever</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>chills</td>
<td>10.</td>
<td>hearing difficulty</td>
<td>18.</td>
<td>swelling</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>congestion</td>
<td>11.</td>
<td>itching</td>
<td>19.</td>
<td>swollen glands</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>coughing</td>
<td>12.</td>
<td>injury</td>
<td>20.</td>
<td>tiredness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>cut</td>
<td>13.</td>
<td>nosebleed</td>
<td>21.</td>
<td>toothache</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>dizziness</td>
<td>14.</td>
<td>rash</td>
<td>22.</td>
<td>visual difficulty</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>earache</td>
<td>15.</td>
<td>sore</td>
<td>23.</td>
<td>vomiting/diarrhea</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>eye irritation</td>
<td>16.</td>
<td>sore throat</td>
<td>24.</td>
<td>other</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Treatment was given: ________________________________________________

If your student continues with the same symptoms, please keep him/her home until symptoms improve or until you have taken him/her to the doctor for evaluation of these symptoms.

_____ Please contact your school nurse to discuss this condition.
Fecha __________

Estimados Padres,

_________ vino a la oficina de salud (enfermo) ______________ expresándose de la siguiente
quejas (male) :

1. __ alergias 9. __ dolor de cabeza 17. __ dolor de estomago 25. __ fibra calentura
2. __ resfriado 10. __ dificultad de oir 18. __ hinchazon
3. __ congestion 11. __ picazon 19. __ hinchazon de las glandulas
4. __ toser 12. __ herida 20. __ fatigado
5. __ cortada 13. __ sangrar de la nariz 21. __ dolor de diente
6. __ mareado 14. __ saipullido y/o ronchas 22. __ dificultad de vision
7. __ dolor de oido 15. __ dolorido 23. __ vomitar/diarrhea
8. __ de ojo irritacion 16. __ dolor de garganta 24. __ otro

El tratamiento que se dio (administro):

___________

Si el estudiante continua con las mismas síntomas, favor de mantenerlo en casa, hasta que las síntomas mejoren y/o
hasta que usted lo ha llevado con el doctor para un evaluacion de estas síntomas.

Favor de communícarse con la enfermera para hablar sobre esta condición.
Dear Parent(s) or Guardian:

Hearing is very important to a student’s ability to listen, learn and progress satisfactorily in school. For this reason, your school takes a special interest in the hearing ability of all students and conducts periodic hearing screenings and assessments. The school nurse performs the initial and follow-up hearing screenings. An audiological evaluation is recommended for students who do not pass the screenings.

Hearing screenings were performed at school by the school nurse. Screening results for ______________ indicate that further hearing testing is advisable. A complete hearing evaluation is available at no charge at the Instructional Resource and Media Center, 4601 State Avenue, Kansas City, Kansas 66102. Please call the Hearing Department at 627-5637 for an appointment.

Thank You,
Pat Murphy, Au.D., CCC/A, Audiologist
U.S.D. 500 KANSAS CITY, KANSAS PUBLIC SCHOOLS  FORM#1
Request That Medication / Treatment Be Performed During School Attendance

Student Name __________________ Grade ___ Teacher ________ School Yr _______

Doctor/Authorized Health Care Provider: Please complete and sign the section below and fax to School Nurse at: 913 627-3088. REC

Medication / Treatment ___________________________ (Treatment Plan Attached) Dosage ______
Date Medication/Treatment Started _____________________________
Time To Be Given At School _____________________________
Duration of Medication/Treatment ____ # Days or ____ School Year
Diagnosis (*Required) ___________________________________
Physician Name (PLEASE PRINT) ________________________________
Physician Signature ___________________________ Date ____________

Parent/Guardian: 1ST Please complete and sign the section below and then give to Doctor to complete and sign the above section
Addendum: Pertinent medical/emergency information regarding my child may be shared with USD 500 faculty and staff who need to know for the health/safety of my child.
Parent/Guardian signature: X __________________________

PARENT CONSENT
I give my permission for my child: ___________________________ to receive the above medication/treatment at school as ordered. I understand that it is my responsibility to furnish the prescribed medication. I further understand that any school employee that administers any drug to my child in accordance with the instructions from the Physician or Dentist shall not be liable for damages as a result of an adverse drug reaction suffered because of the administration of such drug. I authorize appropriate U.S.D. 500 personnel and my child's Doctor/Health Care Provider to exchange verbal/written information regarding the health needs of my child at school.

Parent/Guardian signature: X __________________________ Date ____________
Telephone __________________________________________
Home ________ Work ________ Emergency ________

ALL MEDICATION MUST BE BROUGHT TO SCHOOL IN THE ORIGINAL CONTAINER AND PRESCRIPTION MEDICATION MUST HAVE A PHARMACY LABEL ON THE ORIGINAL CONTAINER
U.S.D. 500 KANSAS CITY, KANSAS PUBLIC SCHOOLS

FORM#1

ESCUELAS PUBLICAS DE KANSAS CITY, KANSAS U.S.D. 500

La HOJA#1

Request That Medication / Treatment Be Performed During School Attendance
Solicitud Para Administracion / Tratamiento De Medicamento Realizada Duraante La Asistencia Escolar

Student Name ___________________________ Grade ________ Teacher _________ School Yr _________
Nombre del estudiante __________________ Grado ________ Maestra/o _________ Ano Escolar _________

Doctor / Authorized Health Care Provider: Please complete and sign the section below

Medication / Treatment ______________________ (Treatment Plan Attached) Dosage _________
Medicamento/Tratamiento ___________________ (Plan de Tratamiento Sujeto) Dosis _________

Date Medication/Treatment Started __________
Fecha Que Medicamento/Tratamiento Empiezo _________

Time To Be Given At School ___________________
Horario Para Darleso En La Escuela ______________

Duration of Medication/Treatment __________ #Days or _________ School Yr _________
Duracion de Medicamento/Tratamiento __________ #Dias o _________ Ano Escolar _________

Diagnosis (*Required) ________________________
Diagnostico (*Requerido) ______________________

Physician Name (PLEASE PRINT) ___________
Nombre Del Medico Letra De Molde Por Favor ___________

Physician Signature ________________________ Date _________
Firma Del Medico __________________________ Fecha _________

Padre/Madre/Guardian: PRIMERO Por favor llene y firme la seccion de abajo y despues darselo a un doctor para que el llene y firme la seccion de arriba.

Anexo: Pertinente información medica y de emergencia con respecto a mi hijo/a puede ser compartida con la facultad y el personal de U.S.D. 500 (Distrito Escolar) quien necesita saber acerca de la salud/seguridad de mi hijo/a.

Firma del Padre/Madre/Guardian: X _______________________

El Consentimiento del Padre/Madre/Guardian

Yo doy permiso para que mi hijo/a: ___________________________ reciba el medicamento/tratamiento de arriba en la escuela como habia sido ordenado. Yo entiendo que es mi responsabilidad de proveer el medicamento recetado. Ademas yo entiendo que cualquier empleado/a de la escuela que administrara cualquiera medicina a mi hijo/a de acuerdo a las instrucciones de un medico o dentista no seria responsoble bajo las leyes en el caso que mi hijo/a tuviera una reaccion adversa a la medicina. Yo autorizo el personal apropiado de U.S.D. 500 y al doctor de mi hijo/a/ proveedor del cuidado de la salud a intercambiar informaciones verbales/escritas con respecto a las necesidades de salud de mi hijo/a en la escuela.

La firma del Padre/Madre/Guardian: X ________________________ Fecha _________

Telefono ____________________________
Casa _______________ Trabajo ____________ Emergencia ________________

Todos los medicamentos deben ser traídos a la escuela en el contenedor original y la medicina recetada. Tambien debe tener encima la etiqueta de la farmacia.
New Immunization Requirements

Student Name_________________________ Date/Year_________________________

There is a new law for school age children in the following grade level (s)
________________. In addition to a complete series of DPT, MMR, and Polio vaccinations,
students must also have a complete series of Hepatitis B and a Varicella (chicken pox)
vaccination.

The vaccinations your child will need for entry to school are checked below.

DPT____________________________________

MMR____________________________________

POLIO__________________________________

HEPATITIS B____________________________

VARICELLA_____________________________
Pass for Health Room

Student's Name: ___________________________ Teacher: ___________________________ Date: ___________________________

Check Reason For Visit

[ ] Head Injury  [ ] Stomach Ache  [ ] Headache  [ ] Bee Sting  [ ] Splinter
[ ] Arm Injury  [ ] Vomiting  [ ] Earache  [ ] Rash  [ ] Puncture
[ ] Leg Injury  [ ] Fever  [ ] Sore Throat  [ ] Other ___________________________

If accident please describe occurrence:

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Action taken/Comments:

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Back to class at _______ AM _______ PM
Parent reached by phone
Sent By: ___________________________

reached by phone
reached by phone
See By: ___________________________

will pick up.

N002
To Parent/Guardian of: ______________________

Your child was seen in the nurse's office at __________________ for a complaint of ________________________

There were no obvious signs of a sprain or fracture at that time. Please observe your child's injury and contact your physician should any of the following signs and symptoms develop:

1. Pain
2. Swelling (compare to opposite side)
3. Inability to move or use extremity normally
4. Numbness or tingling
5. Discoloration (red or blue color)

Please call the nurse's office if you have any questions.

Thank you.

_________________________
School Nurse
Child abuse

If you suspect abuse, you can examine the student and document what you see. Once this is done, you must notify SRS. If you are examining a student, always have 2 people if you need to remove clothing. You are not to investigate further for example take pictures. If you report a case and SRS does not respond, call SRS and speak with the supervisor and inform them that you will notify the police if they are not able to come. If the student is in eminent danger, or tells you he is afraid to go home, call SRS. If they do not respond before school ends, call the police. Once the police are there, you must notify the parent. Again, you may examine and document however we cannot investigate. Please keep you principal aware of the action you have taken.

Who reports:
The person with the evidence (verbal or physical) shall call in the report. It is not the role of the school employee to do the investigative procedures nor is it up to the school administrator to decide whether or not the occurrence should be reported. The statue is clear that the school personnel must report and SRS will investigate.

If the student tells you that he has been abused and/or you noticed markings on the student, you are the reporter.

If the student reports to the teacher about being abused, the teacher is to call SRS. You will be asked to examine the student and document findings. Always keep your documentation separate from you regular charting records.

It is important to remember that a school employee’s obligation is fulfilled by making the initial factual report; it then becomes the responsibility of the Department of Family Services and/or law enforcement agencies to initiate and complete investigation.

Please review Kansas State Law statute (KSA 38-1522) for further information.

Revised 10/3/08

Revised 10/3/08
SCHOOL NURSE POSITION DESCRIPTION

TITLE: School Nurse

JOB GOAL: To provide direct nursing services to students and staff members, and to maximize health and wellness in the school community. All duties are performed in accordance with district/state board of education policies and procedures and state law regarding the Nurse Practice Act.

REPORTS TO:

- Principal
- Health Facilitator
- Director of Special Education

QUALIFICATIONS:

- Current Registered Nurse licensure in Kansas
- Current Cardiopulmonary Resuscitation program completion
- Maintain CPR status according to American Heart Association Guidelines.
- Experience in school nursing preferred
- Computer literacy and competency in use of existing technology preferred

ESSENTIAL FUNCTIONS:

Nursing Care

- Must possess sufficient strength, endurance, and skill to provide direct professional nursing services, first aid, illness, and emergency care to students and staff guided by the nursing process and in accordance with professional standards, school policy and procedures, and state and local mandates.
- Must be able perform CPR and use an AED (if available)
- Administers medication with appropriate documentation.
- Able to perform nursing procedures within their scope of practice.
- Participates in maintaining accurate medical records to assure compliance with state mandates including immunizations, physical examinations, and medical conditions, and the related archival responsibilities.
- Performs mandated screening procedures for vision and hearing.
- Provides follow-up evaluations on students as required.
- Makes appropriate assessment and referrals for suspected abuse/neglect as a mandated reporter.
- Must be able to perform all required activities of job.
- Monitors compliance of school health program with federal, state and local laws, regulations and policies.
- Manages health room efficiently.
- Prepares health reports for supervisor and health department.
- Collaborates with other agencies in designing and providing services to our students.
- Collaborates with teachers in regards to health education according to the state curriculum (K-12).
- Serves as a resource person on health issues.
- Provides staff development on health-related topics for school staff.
- Participates in the development of the school emergency health and crises plan.
• Where applicable, delegating, monitoring and evaluating aides/assistants/staff members in assigned nursing procedures.
• Identification of students with special health care needs.
• Development of emergency action plans for students at risk of medical crises at school or during a school function.
• Monitoring of individual health care plans (IHP) for students who need invasive procedures performed during the school day.
• Provide health related consultation as a member of the Individualized Education Plan (IEP) team.
• Ability to work an 8 hour duty day in the location or locations assigned by the supervisor.
• Physical and emotional ability to perform required work and move about as needed in the fast-paced, highly intensive school environment.

Communication

• Maintains communication with the teachers, other school personnel, and parents/guardians to enhance cooperative action which will meet the health and safety needs of students.
• Provides health services, information, and counseling in an effective and positive manner to enhance the health and wellness of the school community.
• Completes accident/incident reports for students/staff.
• Compiles data for statistical purposes.
• Maintains confidentiality regarding all school health-related issues.

Organization

• Maintains a daily log of student/staff visits and documentation on individual health records
• Maintains the daily environment of the health office facility and supplies
• Utilizes existing technology effectively in the performance of duties.
• Performs other health or school related work as required.

Professionalism

• Maintains contact with a professional nursing organization and utilizes continuing education opportunities to enhance professional knowledge
• Participates as an active member of the school community, representing health/wellness.
• Attends nursing in-services as specified by district
• Maintains a neat and appropriate appearance

SALARY BASED ON USD 500 SALARY SCHEDULE

TERMS OF EMPLOYMENT: 186 Days

EVALUATION: Performance will be evaluated in accordance with evaluation procedures and Board policy 4.2.9.0.0