AMERICAN RENAISSANCE SCHOOL

Kindergarten Health Records

NC Health Assessment Form and Immunization records are due:

JULY 31

I. Do you have a student going into Kindergarten?

✓ If yes, an ***up-to-date immunization record*** (see state requirements below) and a current ***NC Health Assessment Form*** (see attached) must be provided to the school nurse within 30 calendar days of attendance. The Health Assessment must have been done within one (1) year prior to the first day of school attendance.

The following vaccinations are required for entry into Kindergarten:

Diphtheria, tetanus, and pertussis- 5 doses

Polio- 4 doses

Measles, Mumps, Rubella (MMR)- 2 doses

Haemophilus Influenzae type B (Hib)- 3-4 doses

Hepatitis B (Hep B)- 3 doses

Varicella (chickenpox)- 2 doses

Pneumococcal conjugate- 4 doses

II. Do you know about the 30-calendar days rule, a North Carolina law?

✓ The parent/legal guardian is responsible for submitting all required documents (listed above) to the school within 30 calendar days of school attendance.

✓ Students who do not meet the requirements are not allowed to attend school.

OVER →

Medications at School

A MEDICATION REQUEST FORM must be filled out and signed by physician **AND** parent/guardian, for any medications to be given or taken at school. *These may be found on the ARS website, under Resources/ Parents/Files/Medication Request Form.*

School Staff/Nurse may not give **ANY** type of medication without a completed medication form. *This includes prescription and nonprescription medications such as Tylenol, Motrin, Tums, cough drops, Benadryl, antibiotic ointments, cough medicine, etc.*

Parent must provide medication.

Medication must be brought to school in original labeled container.

Parent must check in all medications with School Nurse.

New medication forms should be provided at the beginning of each school year.

Parent is responsible for picking up any leftover medications at the end of the school year.

Medical Issues/Allergies

Please contact the School Nurse if your child has any of the following:

Allergies that require EpiPen or Benadryl
Asthma
Diabetes
Hearing problem
Bleeding disorder
Gastrointestinal problem
Heart Problem
Kidney Problem
Migraine Headaches
Bone Problem
Seizures
Sickle Cell Disease
Special Diet
Vision Problem
Special Needs
Other Conditions or Concerns

PUBLIC SCHOOLS OF NORTH CAROLINA
State Board of Education | Department of Public Instruction

January 2016

NORTH CAROLINA HEALTH ASSESSMENT TRANSMITTAL FORM

This form and the information on this form will be maintained on file in the school attended by the student named herein and is confidential and not a public record.
(Approved by North Carolina Department of Public Instruction and Department of Health and Human Services)

PARENT to COMPLETE THIS SECTION

Student Name: ☐ M ☐ F

(Last) (First) (Middle)

Birthdate (M/D/YYYY): **School Name:**

Hispanic of Latino Origin: ☐ 1 Yes ☐ 2 No

Race: ☐ 1 Other Non-White ☐ 2 White ☐ 3 Black ☐ 4 American Indian ☐ 5 Chinese ☐ 6 Japanese ☐ 7 Hawaiian ☐ 8 Filipino ☐ 9 Other Asian ☐ 10 Unknown

Home Address: **City:** **State:** **County:**

Parent Information: Name of Parent, Guardian, or person standing in loco parentis:

Telephone(s)

Home:

Work:

Cell Phone:

Health Concerns to be shared with authorized persons (school administrators, teachers, and other school personnel who require such information to perform their assigned duties):

HEALTH CARE PROVIDER TO COMPLETE THIS SECTION

Medications prescribed for student:

Student's allergies, type, and response required:

Special diet instructions:

Health-related recommendations to enhance the student's school performance:

Vision screening information:
Passed vision screening: ☐ Yes ☐ No
Concerns related to student's vision:

NC Public Health
HEALTH AND HUMAN SERVICES

January 2016

Hearing screening information:
Passed hearing screening: ☐ Yes ☐ No
Concerns related to student's hearing:

Recommendations, concerns, or needs related to student's health and required school follow-up:

School follow-up needed: ☐ Yes ☐ No

Medical Provider Comments:

Please attach other applicable school health forms:

Immunization record attached: ☐
School medication authorization form attached: ☐
Diabetes care plan attached: ☐
Asthma action plan attached: ☐
Health care plans for other conditions attached: ☐

Health Care Professional's Certification
I certify that I performed, on the student named above, a health assessment in accordance with G.S. 130A-440(b) that included a medical history and physical examination with screening for vision and hearing, and if appropriate, testing for anemia and tuberculosis. I certify that the information on this form is accurate and complete to the best of my knowledge.

Name: Title:

Signature: _____ Date (m/d/yyyy):

Practice/Clinic Name:			Practice/Clinic Address:	
Practice/Clinic City:	State:	Zip:	Phone:	Fax:

Provider Stamp Here:

American Renaissance School

"A Downtown Community School"

Request for Medication Administration in School

To be completed by physician

Name of Student: _____
School: _____

Medication: (each medication is to be listed on a separate form)
_____

Dosage and Route: _____

Time(s) medication is to be given: a.m. _____ p.m. _____PRN: _____
To be given from: (date) _____ to/through: _____

Significant Information (include side effects, toxic reactions, reactions if omitted, etc.)
_____

Contraindications to administration:_____

If an emergency situation occurs during the school day or if the student becomes ill, school officials are to:

a. Contact me at my office_____
b. Telephone _____

Take child immediately to the emergency room at _____

FOR SELF-ADMINISTRATION –
☐ **Student has demonstrated ability and understands the use of and may carry and self- administer asthma medication, diabetes medication, or medicine for anaphylactic reactions only.**

Asthma/allergic reaction __MDI (*Metered Dose inhaler) __MDI with spacer * Diabetes __ insulin __ glucose __Epinephrine

*Parent/guardian must provide an extra inhaler/epinephrine injector/source of glucose to be kept at school in case of emergency and that will be replaced when it expires.
A written statement, treatment plan and written emergency protocol developed by the student's health care provider must accompany this authorization form in accordance with requirements stated in G.S. 115C –375.2 The student also must have a self-medication agreement on file.

Date _____ Physician's Signature_____

(Over)

Elementary: 111 Cooper Street • Statesville, NC 28677 • 704-924-8870 • Fax 704-873-1398
Middle: 217 S. Center Street • Statesville, NC 28677 • 704-878-6009 • Fax 704-878-9350
Website: www.arsnc.org

PARENT'S PERMISSION

I hereby give my permission for my child (named above) to receive medication during school hours. This medication has been prescribed by a licensed physician. I hereby release the School Board and their agents and employees from all liability that may result from my child taking the prescribed medication. This consent is good for the school year, unless revoked.

I will furnish all medication for use at school in a container properly labeled by a pharmacist with identifying information, (name of child, medication dispensed, dosage prescribed, and the time it is to be given or taken) and replace the medication when it expires.

Parent or Guardian's Signature: _____

Telephone Number _____ Date: _____

(School Use Only)

Name and title of person to administer medication (unless self-administered)_____

Approved by_____ _____

Principal's Signature Date

Reviewed by_____ _____

School Nurse's Signature Date

SCHOOL ASTHMA RECORD

NAME OF STUDENT _____ SCHOOL _____

GRADE _____ YEAR _____

PARENT/GUARDIAN #1_____ PHONE _____

PARENT/GUARDIAN #2_____ PHONE _____

HEALTH CARE PROVIDER _____ PHONE _____

1. Briefly describe what causes the child's asthma symptoms (weather, cold, allergies, exercise):
2. How often does the child have a bad enough asthma attack that he/she needs to see a health care provider or go to the hospital?
3. Name any medication that the child takes for his/her asthma attack (how often and how much):
   at home _____
   at school _____
4. Does your child suffer any side effects from these medications? Please list them:
5. Name any activities/exercise in which your child CANNOT participate:
6. What does your child do at home to relieve wheezing during an asthma attack? Please check all that apply.
   ___Breathing exercises
   ___ Rest/relaxation
   ___ Drinks liquids
   Takes medicine: ___ Inhaler
   ___ Nebulizer
   ___ Oral medicine
7. Do you know what your child's baseline peak flow rate is?
   ___ No ___ Yes What is it? _____
8. How do you want the school to treat an asthma attack if it should happen?

PLEASE READ THE EMERGENCY ACTION PLAN FOR ASTHMA ON THE REVERSE SIDE AND ADD ANY FURTHER INSTRUCTIONS THAT YOU WISH FOR YOUR CHILD.

STUDENT NAME _____

EMERGENCY ACTION PLAN

ASTHMA

SYMPTOMS: Difficulty breathing with short inhalations and longer exhalations, rapid, shallow breathing, wheezing (high-pitched noise heard with breathing), excessive coughing (may cause vomiting), sensation of chest tightness, flaring of nostrils, tingling/numbness in fingers/toes, loss of color in lips.

INTERVENTIONS:

1. Attempt to calm student. Stay with student.
2. Have student rest in a sitting position, breathing slowly through mouth, exhaling slowly through pursed lips.
3. Offer fluids.
4. Have student take prescribed medication as ordered by hearth care provider and parent.
5. Notify school nurse if in building.
6. Notify parent of severe breathing difficulty or if medication is not effective in 15 minutes.
7. If parent is unavailable or student is having extreme difficulty breathing, call 911 and transport to _____ Hospital.
8. Additional instructions:

PARENT/GUARDIAN SIGNATURE _____ DATE _____

SCHOOL NURSE_____ DATE _____

PLEASE NOTE: If medication or inhaler are to be taken at school, a medication authorization form must be completed by parent and physician and kept at the school. This form is to be completed each year.

This information will be shared with your child's teacher unless you state otherwise.

School Nurse Health Information and Emergency Contact (Must be completed annually)

Student's Name:_____ Date of Birth:_____ Teacher/Grade:_____
Before/After school: yes/no Parent/Guardians: _____
Emergency Numbers: (*List in the order to be called)*

Name	Relationship	Daytime #
_____	_____	_____
_____	_____	_____
_____	_____	_____

Physician_____ Office Phone _____ Hospital Preference:_____
Insurance Company:_____ Policy Number:_____
Head injury/Concussion within the past year: ☐ yes ☐ no
If yes, Date and description of injury: _____
Drug Allergy(s): ☐ None known ☐ Yes (list) _____

Asthma Triggers: ☐ environmental ☐ seasonal ☐ exercise induced Inhaler at school-☐ yes ☐ no
MD order required Inhaler location: ☐ Carried by student (must be on MD order) ☐ Classroom ☐ Nurse's office

Diabetes ☐ Type I ☐ Type II Diagnosis Date: _____ Insulin by: ☐ Pump ☐ Injections
Diabetes Care Plan: ☐ yes ☐ independent with all care Glucagon:☐ yes ☐ no
Please call for Nurse Conference- Notify your school nurse and principal immediately if newly diagnosed

Food Allergy: ☐ Peanuts ☐ Tree nuts ☐ Milk ☐ Other _____
Date/Type of Last Reaction: _____
Student Needs during school day: _____
Diet/Medication Orders signed by MD required

Severe Sting Allergy:
Date/Type of Last Reaction: _____

****Notify your school nurse and principal immediately if anaphylaxis may occur****

Seizures:
☐ controlled with medication ☐ medication needed at school ☐ no medication needed at school
Date and type/description of last seizure: _____

Other conditions or information to help us better serve your child: _____
_____

Does your child take routine medication(s) ☐ yes ☐ no List meds: _____

Does your child need medication(s) at school? ☐ yes ☐ no List meds: _____

If your child needs medication (prescription or over the counter) during the school day, a medication consent form is required to be signed by the health care provider and the parent/guardian. ****Medication cannot be given at school until appropriate consents have been received.

I authorize all emergency transportation, medical and surgical treatment, X-ray, laboratory, anesthesia, and/or medical or hospital procedures as may be performed or prescribed by the attending physician and/or paramedic for my child and waive my right to informed consent of treatment. This waiver applies only in the event that neither parent/guardian can be reached in the case of an emergency.
Parent/Guardian: _____ Date: _____

A health care provider's written diagnosis is required in order for an Individualized Healthcare Plan to be developed by the school nurse. Also, please let your school nurse know if your child participates in extracurricular school activities.