AMERICAN RENAISSANCE SCHOOL

Kindergarten Health Records

NC Health Assessment Form and Immunization records are due:
JULY 31

Do you have a student going into Kindergarten?

If yes, an **up to date immunization record** must be provided to the school nurse within 20 calendar days of attendance. The Health Assessment must have been done within one(1) year prior to the first day of school.

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

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.

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. *Please see attached forms.*

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, chap stick/lip balm, etc.*

Parents must provide medication.

Medication must be brought to school in the original labeled container.

Parents must check in all medications with the school nurse.

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

Parents are 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 requiring EpiPen or Benadryl
Asthma
Diabetes
Hearing Problems
Bleeding Disorder
Gastrointestinal Problems
Kidney Problems
Bone Problem
Seizures
Sickle Cell Disease
Special Diet
Vision Problems
Special Needs
Heart Problems
Migraine Headaches
Other conditions or concerns

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 include vomiting), sensation on chest tightness, flaring of nostrils, tingling/numbness in fingers/toes, loss of color in lips.

INTERVENTIONS:

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

PARENT/GUARDIAN SIGNATURE_____ DATE _____

SCHOOL NURSE SIGNATURE _____ 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 ASTHMA RECORD

NAME OF STUDENT_____ SCHOOL _____
GRADE _____ YEAR _____
PARENT/GUARDIAN #1 _____ PHONE _____
PARENT/GUARDIAN #2 _____ PHONE _____
HEALTHCARE 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:
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
   - ☐ Drink 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.

AMERICAN RENAISSANCE SCHOOL

REQUEST FOR MEDICATION ADMINISTRATION IN SCHOOL

To be completed by physician

Name of Student: _____

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

Dosage and Route: _____

Time(s) medication is to be administered: 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: _____

C. Take child immediately to the emergency room at (hospital) _____

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* ___ Epinephrine ___ Diabetes ___ insulin ___ glucose

*Parents/guardians 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 the requirements stated in G.S. 115C-375.2. The student also must have a self-medication agreement on file.

Physician's Signature _____ Date _____

Continued on other side

REQUEST FOR MEDICATION ADMINISTRATION IN SCHOOL

PARENT'S PERMISSION

I hereby give my permission for my child, _____, 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 Signature Date

January 2016rev

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

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:

(Last) (First) (Middle)

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

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:

Public Health
HEALTH AND HUMAN SERVICES

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):

Date of Exam (if Different):

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

Provider Stamp Here: