Lowndes County School District

STUDENT HEALTH SERVICES POLICIES

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Exhibits:
LOWNDES COUNTY School District
Columbus, Mississippi

A MESSAGE FROM THE SCHOOL NURSE

Dear Parent:

We would like to make you aware of the Lowndes County School District's policy regarding medication administration. If your child MUST have medication of ANY TYPE during school hours, including over the counter medications, you have the following options:

1. You may come to school and give the medication to your child at the appropriate time(s).

2. You may obtain a copy of the Medication Authorization form from the school office or school nurse. (One is also provided in the Student Handbook.) Take the form to your child's doctor and have him/her complete the form by listing the medication needed, dosage, and number of times per day the medication is to be given. The physician must complete the form for both prescription and over the counter medications. A doctor and parent must sign the form.

3. You may discuss with your doctor any alternative schedule for administering medication (e.g., outside of school hours).

The parent must provide all medications. LOWNDES COUNTY SCHOOLS DO NOT PROVIDE ANY MEDICATION FOR STUDENTS. Prescription medicines must be brought to school in a pharmacy labeled bottle, which contains instructions on how and when the medication is to be given. Over the counter medicines must be in its original container and will be administered according to the doctor's written instructions. Parents must bring all medication to the school office. Do not send medications by students on the school bus.

School personnel will not administer any medication to students until they have received the medication form completed and signed by the doctor, along with the medication in appropriately labeled container. IN FAIRNESS TO THOSE GIVING THE MEDICATION AND TO PROTECT THE SAFETY OF YOUR CHILD, THERE WILL BE NO EXCEPTIONS TO THIS POLICY.

Thank you for your cooperation,

_____
Superintendent of Education

JGCD (Form) Board approval:

District: Lowndes County School District
Section: J.- Students
Policy Code: JGC- Student Health Services

Policy:
STUDENT HEALTH SERVICES

Although the district's primary responsibility is to educate students, the students' health and general welfare is also a major concern. This Board therefore believes school programs should be conducted in a manner that protects and enhances student and employee health and is consistent with good health practices.

REQUIREMENTS IN NO CHILD LEFT BEHIND

In accordance with the requirements of the No Child Left Behind Act of 2001, this district will send parents advance notification of any non-emergency, invasive physical examination or screening that is required as a condition of attendance, that is administered and scheduled by the school in advance, and is not necessary to protect the immediate health and safety of the student, or of other students.

Notification will be sent annually at the beginning of the school year or when enrolling students for the first time each year and will included the specific or approximate dates when such activities are scheduled or expected to be scheduled.

"Invasive physical examination" means any medical examination that involves the exposure of private body parts or any act (during such examination) that includes incision, insertion, or injection into the body. The term does not include hearing, vision, or scoliosis screening or any physical examination/screening that is permitted or required by state law, including physical examinations/screenings that are permitted without parental notification.

Procedures shall be developed and implemented to carry out this policy. All district employees will be appraised of their responsibilities in this area. Parents shall have the opportunity to request that their children be exempt from participation in (scoliosis) vision or hearing screening. The district will abide by these requests.

GENERAL PROVISIONS

This district maintains a prevention-oriented health program which provides:

1. Pertinent health information on all students, as required by Mississippi statutes or rules.
2. Health appraisal that includes screening for possible vision or hearing problems and scoliosis.
3. Health counseling for students and parents when it is appropriate.
4. Health care and first-aid assistance that are appropriately supervised and isolate the sick or injured child from the student body.
5. Control and prevention of communicable diseases as required by the Mississippi Department of Human Services, Health Services and the county health department.
6. Assistance for students in taking prescription and/or non prescription medication according to established district procedures.
7. Services for students who are medically fragile or have special health care needs.
8. Integration of school health services with school health education programs.

NURSES

The nurses employed by the district shall be licensed to practice as a registered nurse or nurse practitioner in Mississippi. They will also function as an integral member of the instructional staff by serving as a resource person to help teachers secure appropriate information and materials on health-related topics. IN addition, they will coordinate with health personnel from other public agencies in matters pertaining to health instruction or the general health of students and employees.

A school district will establish a local school health advisory council to assist in ensuring the local community values are reflected in the district's health and physical education instruction. `37-13-134 (2003)

LEGAL REF.: MS CODE as cite; P.L. 107-110 (no Child Left Behind Act)
Mississippi Public School Accountability Standards (2002)

CROSS REF.: Policies JGB- Medical Exam for Athletes
JGCB- Inoculations
JGCC- Communicable Diseases
JGCD- Medicines

Exhibits:

Regulations:

Adopted Date:
Approved/Revised Date:

District: Lowndes County School District
Section: J- Students
Policy Code: JGCB- Student Health Services Inoculations
Policy

INOCULATIONS

This school board has power, authority, and duty to require those vaccinations specified by the state health officer as provided in Section 41 23 37. `37 7 301 (i).

Whenever indicated, the state health officer shall specify immunization practices that are considered best for the control of vaccine preventable diseases. A listed shall be promulgated annually or more often, if necessary.

Expect as provided hereinafter, it shall be unlawful for a child to attend any school, kindergarten, or facility intended for the instruction of children, either public or private (with the exception of any legitimate home instruction program as defined in Section 37 13 9), unless they have been vaccine against those diseases specified by the state health officer.

A certificate of exemption from vaccination for medical reasons may be offered on behalf of a child by a duly licensed physician and may be accepted by the local health officer if, in his/her opinion, such exemption will not cause undue risk to the community.

Certificates of exemption from vaccination for medical reasons may be offered on behalf of a child by a duly licensed physician and may be accepted by the local health officer if, in his/her opinion, such exemption will not cause undue risk to the community.

Certificates of vaccination shall be issued by local health officers or physicians on forms specified by the Mississippi State Board of health. These forms shall be the only acceptable means for showing compliance with these immunization requirements, and the responsible school officials shall file the form with the child's record.

If a child tries to enroll in school without the required vaccinations, the local health officer may grant the student up to ninety (90) days for such completion if it will not cause undue risk to the child, school, or community. No child shall be permanently enrolled without having had at least one (1) dose of each specified vaccine.

Within thirty (3) days after the opening of school (on or before October 1 of each year), the delegated person in each school shall report to the county or local health officer (on forms provided by the Mississippi State Board of Health) the number of children enrolled by age or grade (or both), the number fully vaccinated, the number in the process of completing the vaccinations, and the number exempt from vaccinations and for what reasons.

Within one hundred twenty (120) days after the opening of school (on or before December 31), the delegated person in each school shall certify to the local or county health officer that all children enrolled are in compliance with immunization requirements.

To assist in the supervision of the immunization status of the children, the local health officer (or designee), may inspect the children's records or be furnished certificates of immunization compliance by the school.

It shall be the responsibility of the person in charge of each school to enforce the requirements for immunization. Any child not in compliance at the end of ninety (90) days from the opening of the fall term must be suspended until they are in compliance, unless the health officer attributes the delay to lack of supply of vaccine or some other factor clearly making compliance impossible.

Failure to enforce provisions of this section shall constitute a misdemeanor and upon conviction be punishable by fine or imprisonment or bot. `41 23 37 (1983)

LEGAL REF.: MS CODE as cited

CROSS REF.: Policies JGB- Medical Exam for Athletes
JGC- Student Health Services
JGCC- Communicable Diseases
JGCD- Medicines

Exhibits:
Regulations:
Adopted Date:
Approved/Revised Date:

District: Lowndes County School District
Section: J- Students
Policy Code: JGCC- Communicable Diseases
Policy

COMMUNICABLE DISEASES

It is unlawful for any child to attend school with a dangerous, contagious, or infectious disease. If a student comes down with an infectious disease at school, he/she will be immediately isolated until he/she can be taken home or picked up by the parent/guardian. Under no condition will the student be allowed to ride the bus home. In addition, the student will not be permitted to return to school without a permission slip from a doctor or health department official. `37 7 301 ()h)

HEAD LICE

If a student has head lice and on three (3) consecutive occasions during one (1) school year, the principal/ school nurse shall notify the county health department and or physician of the recurring problem. The student shall not be allowed to attend school until proof of treatment is obtained. `41-79-21

EDUCATING STUDENTS WITH CHRONIC INFECTIOUS DISEASES POLICY

The following shall be the policy of this school district for educating students with a chronic infectious disease (persistent illness or compared to an acute short term self limiting illness) such as, but not limited to, hepatitis B, herpes simplex, AIDS/ARC or cytomegalovirus.

1. The student shall be removed from the classroom until the district's medical advisor consults with the student's physicians and determines whether the student's presence in the school poses a risk of transmission of the infectious disease to others.
2. If the medical advisor determines that attendance poses no threat, the student may resume attendance at school subject to any restrictions or limitations the medical advisor may recommend. The student's attendance shall be reviewed by the medical advisor (in consultation with the student's physician) at least once a month to determine if continued school attendances poses any risk of transmission of the disease to others.
3. If the medical adviser determines that attendance at school poses a risk of transmission of the disease to others, an appropriate alternative education program shall be established for that student which will continue until the medical adviser determines the risk of transmission to others has abated and normal school attendance can resume.
4. The district's medical advisor's decisions shall be final.

LEGAL REF.: MS CODE as cited

CROSS REF.: Policies JGB- Medical Exam for Athletes
JGCB- Inoculations
JGC- Student Health Services
JGCD- Medicines

Exhibits:

Regulations:

Adopted Date:
Approved/Revised Date:

District: Lowndes County School District
Section: J- Students
Policy Code: JGCDA- Asthma Medications
Policy

ASTHMA MEDICATION POLICY

A student with asthma may possess and use asthma medications when at school, at a school-sponsored activity, or before and after normal school activities while on school properties (including school-sponsored child care or after-school programs) according to the guidelines set forth by the MDE and outlined in this policy. Emergency Epinephrine is also included in this policy if required for treatment of severe life threatening allergies.

REQUIRED AUTHORIZATION

Students may self-administer asthma medication if their parent or guardian:

1. Provides written authorization or self-administration form to the school
2. Provides a written statement from the student's health care practitioner that the student has asthma and has been instructed in self-administration of asthma medications. The statement shall also contain the following information:
    - The name and purpose of the medications
    - The prescribed dosage
    - The time (s) the medications are to be regularly administered and under what additional special circumstances, if any
    - The length of time for which the medications are prescribed.
    - The signature of the child's health care practitioner, along with the date

The documentation listed above shall be kept on file in the school's office or nurse's office.

INDEMNIFICATION AND LIABILITY

Parents/Guardians shall be informed that the school and its employees and agents shall incur no liability as a result of any injury sustained by the student from the self administration of asthma medications. The parent/guardian shall sign a statement acknowledging the school shall incur no liability, and he/she shall indemnify and hold harmless the school and its employees against any claims relating to the self-administration of asthma medications

YEARLY RENEWAL

The permission for self-administration of asthma medications shall be effective for the school year in which it is granted and must be renewed each following school year.

LEGAL REF.: House Bill 1072, 2003 Mississippi Legislative Session
CROSS REF.: Policy JGCD- Medicines

Exhibits:

FIRST AID TRAINING

Principals shall see that one-third of the instructional staff of the school is currently certified by the American Heart Association to administer first aid and CPR. All physical education teachers in the secondary schools shall be currently certified to give first aid and CPR.

District: Lowndes County School District
Section: J- Students
Policy Code: JGFG- Accidents/First Aid
Policy

ACCIDENTS/ FIRST AIDS

Every accident in the school building, on school grounds, at practice sessions, or at any athletic event sponsored by the school must be reported immediately to the person in charge and to someone in the school office. All accident forms must also be completed and sent to the school nurse to be filed. All supervising staff must complete a memo-to- record account of the accident.

In the event that a child needs medical attention and a parent or other designated person cannot be reached, an ambulance will be called at the parent's expense.

PROGRAM OF FIRST AID

Each principal shall have a written program for handling emergencies resulting from accidents or sudden sickness of students. The program shall be approved by the superintendent. This first aid program shall provide direction for giving immediate care, notifying parents/guardians, getting the student home, and directing the parent, when necessary, to the source of treatment. The program of first aid shall incorporate the following requirements.

1. The principal or another trained person shall be responsible for administering first aid.
2. If the illness or injury appears to be serious, every effort shall be made to contact the parent and/or family physician immediately.
3. No student who is ill or injured shall be sent home alone. He/She shall not be taken home unless someone is there to receive him.
4. In extreme emergencies, the principal may make arrangements for hospitalization of injured or ill students, contacting the parent/guardian in advance if possible.
5. The teacher/staff member responsible for the student at the time of an accident shall make out a report providing details about the accident. Reports shall be maintained by the building level school nurse for proper disposition.
6. Serious accidents to students shall be reported as soon as possible to the superintendent

FIRST AID SUPPLIES

Principals shall maintain an adequate supply of first aid supplies which shall be made available as are other school supplies.

STUDENT INJURIES

All staff shall use the following procedures when cleaning up after a student who has an accident or injury at school or when dealing with the vomit and bodily waste of any student:

1. Blood or body fluids emanating from any student, including ones who have a chronic infectious disease, shall be treated cautiously.
2. Rubber gloves shall be worn when cleaning up blood spills. These spill shall be disinfected with a solution of bleach and water (1 part bleach to 7 parts water), and person coming in contact with the spills shall wash their hands immediately.
3. Blood soaked items shall be placed in leak proof bags for washing or further disposition.
4. Hands shall be washed immediately after contact

The school district shall provide gloves and other appropriate materials for the staff's use in compliance with this policy.

ACCIDENT REPORTING

Each principal shall report all injuries to students/employees that require medical attention or keep the student/ employee from school/work one-half day or more. The report shall be made on the district's accident report form.

MEDICATION

School personnel shall not exceed the standard practice of competent first aid. They shall not diagnose, and they shall not administer medication of any kind.

Follow up:
Signature
Principal, Teacher

THE SCHOOL NURSE CAN BE CONTACTED AT THE FOLLOWING NUMBERS

	School Phone #	Nurse Direct Phone #
Caledonia Elementary	(662) 356-2050	(662) 356-2056
Caledonia Middle	(662) 356-2042	Call front office
Caledonia High	(662) 356-2001	Call front office
New Hope Elementary	(662) 244-4760	(662) 244-4771
New Hope Middle	(662) 244-4780	(662) 244-4774
New Hope High	(662) 244-4740	Call front office
West Lowndes Elementary	(662) 244-5050	(662) 244-1204
West Lowndes Middle	(662) 244-5060	(662) 244-1102
West Lowndes High	(662) 244-5070	(662) 244-5070

Regulations:

Adopted Date:
Approved/Revised Date:

District: Lowndes County School District
Section: J- Students
Policy Code: JGCD- Student Health Services-- Medicines
Policy:
MEDICINES

The following medicine policy will be adhered to in the Lowndes County School District:

1. Parents must provide all medications to be given at school. Lowndes County Schools do not provide any medication for students.
2. In order for a student to take **ANY** medication (**including all over the counter medications, such as Tylenol or Advil)** at school, the parent must obtain a medication authorization form from the school nurse or school office, or print it from the school website, and have it completed and signed by the doctor. The parent must also sign the form and bring the completed form along with the medication to the school nurse.
3. **Parents should not send medication to school by the student.**
4. Prescription medication must be brought to school in the pharmacy labeled bottle, which contains instructions on how and when the medication is to be given. Over the counter medications must be in its original container.
5. The principal of each school will designate someone to administer all medication. The designee, if not the nurse, will be given instruction or training to insure he/she can safely administer the medications.
6. School personnel will follow the written direction of the student's physician in administering all medication.
7. Students are admonished and instructed not to bring any medication to school, including over the counter medications. Any student bringing medication to school and giving it to another student will be disciplined.
8. **For children known to have severe or life threatening allergies [or serious medical conditions (seizures, diabetes, asthma etc., that require emergency medications)] parents should.**
    a. Inform the school nurse and the child's teacher of their child's life threatening condition a the beginning of the school year, or as soon as possible after the diagnosis. All server allergies must be verified by documentation from a Physician or Nurse Practitioner.
    b. Complete and submit all required medication forms.
    c. Provide the school with current cell phone, pager, etc. and maintain updated contact numbers and medical information.
    d. Provide the school nurse with up-to-date emergency medication (including epinephrine, diastat, glucagon), so they can be placed in all required locations for the current school year.
    e. Provided epinephrine, diastat, glucagon or any other emergency medication on field trips.
    f. Go on field trips with their children if possible. If a student has emergency medication for seizures, diabetes, or any other medical conditions that require close supervision, a parent or adult chosen by the parent will be required to ac company the child, or the child will not be able to attend the field trip.
    g. Inform the school of any changes in the child's life threatening allergy status.
    h. Provide the school with physician's statement if the student no longer has life threatening allergies or other medical conditions.

District: Lowndes County School District
Section: J- Students
Policy Code: JGCD- Student Health Services-- Medicines (cont.)
Policy:
MEDICINES

i. For food allergies that may cause a need for the diet to be changed from the regular meal pattern in the cafeteria, a **Mississippi Department of Education Office of Child Nutrition Medical Statement** (for Non-Disable or Disabled Child) should be completed by the student's Doctor at the beginning of the school year or as soon as diagnosed. The parent can obtain a copy of this form from the school nurse, the school office, or the school website.

All necessary permission slips, request forms, etc., must be signed before the above and foregoing policy is carried out in relation to administering any medication to the student.

The Lowndes County School district will administer first aid and emergency treatment to insure the safety of its students.

CROSS REF: Policies JGB- Medical Exam for Athletes
JGC- Student Health Services
JGCB- Inoculations
JGCC- Communicable Diseases

Medical Statement for Disabled Child

Mississippi Department of Education
Office of Child Nutrition
Medical Statement for Disabled Child

Part I *(to be completed by School District/School/Organization/Sponsor)*

Date _____

Name of School District/School/Organization/Sponsor _____

Name of Student/Disabled Person _____

Address _____

_____Date of Birth _____

School/Provider/Center Name _____

School/Provider/Center Address _____

Part II *(to be completed by the Physician)*

Patient's Name _____ Age _____

Diagnosis _____

_____

Does the disability restrict the individual's diet? Yes _____ No _____

If yes, list food(s) to be omitted from diet and food(s) that may be substituted _____

_____

_____

Special equipment needed _____

_____

_____

_____ _____

Date Signature of Physician

Medical Statement for Non-Disabled Child

Mississippi Department of Education
Office of Child Nutrition
Medical Statement for Non- Disabled Child

Part I *(to be completed by School District/School/Organization/Sponsor)*

Date _____

Name of School District/School/Organization/Sponsor _____

Name of Student/Individual_____

Address _____

_____Date of Birth _____

School/Provider/Center Name _____

School/Provider/Center Address _____

Part II *(to be completed by Medical Authority)*

Patient's Name _____ Age _____

Diagnosis _____

_____

Describe the medical or other special dietary needs that restrict the child's diet _____

_____

_____

If yes, list food(s) to be omitted from diet and food(s) that may be substituted _____

_____

_____

Special equipment needed _____

_____

_____

_____ _____

Date Signature of Medical Authority

LOWNDES COUNTY SCHOOL DISTRICT
Medication Authorization for Self-Administration

School Name:	Date of Birth:
School:	Grade:
Mother's Name:	Phone Hm: Work/Cell:
Father's Name:	Phone Hm: Work/Cell:
Physician's Name:	

_____This student may carry and self-administer the following medications at school.

_____This student may carry the following medication for administration BY school personnel.

Name of medication: _____

Dosage:_____Time: _____

Start Date: _____End Date: _____

Symptoms that may indicate need for medication:

_____

_____

Factors that may trigger/precipitate symptoms:

_____

_____

Specific instructions if student has symptoms:

_____

_____

PHYSICIAN APPROVAL

I agree with the above medication plan, including the name, purpose, dosage and administration directions of the medication.

It is my professional opinion that this student should be permitted to carry and self-administer this medication.

_____

Physicians Signature Date

PARENTAL CONSENT & RESPONSIBILITIES

I, the parent/guardian of he above named child, understand and agree to the conditions of the school policy on medication administration. I permit the school to seek emergency medical treatment for my child when deemed necessary and appropriate. I give authorization for self– administration and possession of the named medication by my child while at school, at school-sponsored activities, while under the supervision of school personnel and while in before-or after-school care on the school property. My child demonstrates a full understanding of the proper use of this medication.

I am responsible for: (1) Monitoring the medication, medication use, and supplying the medication. (2) Ensuring my child always carries this medication on his/her person. (3) Deciding if back-up medication will be kept at school, and providing the school with back-up medication. (4) Informing the school in writing of any changes in treatment or medical condition of my child. (5) Informing the school of any medication side effects of which I should be notified.

I consent for the physician to release information about my child related to this medication to the school nurse.

I release Lowndes County School District its employees of any legal responsibility related to my child's possession and self-administration of this medication.

_____

Parent/Guardian Signature Date

STUDENT AGREEMENT: I understand and agree to follow the Lowndes County School District's policy for self-administration of my medication while ate school. I have been instructed in the proper use of this medication. I will be responsible for carrying the medication and will not allow another student to use my medication under any circumstances.

_____

Student Signature Date

LOWNDES COUNTY SCHOOL DISTRICT
MEDICATION AUTHORIZATION FORM

Medication will be administered in the school ONLY when it is necessary for a student to remain in school. Medication should be brought to school by the Parent/guardian for a student ONLY WHEN IT IS AN ABSOUTE NECESSITY.

The purpose of this policy is to ensure that students receive necessary medication according to their physician's orders and to ensure maximum safety for all concerned. Please understand that your signature on this form authorizes other school personnel to supervise your child with medication administration when the school nurse is not available.

Should you be asked to complete one of these forms, please read the form thoroughly and respond to ALL items. Contact the school nurse if you have any questions. THANK YOU.

One form must be completed ANNUALLY fore EACH medication PRESCRIPTION.

PHYSICIAN'S STATEMENT:

Date: _____

Student's Name: _____ Date of Birth: _____

Diagnosis: _____

Name of Medication: _____ Dosage _____

Time of Administration: _____ Termination Date: _____

Side Effects/Special Instructions for Medication:

Physician's Signature: _____ Phone: _____

Physician's Name (Print): _____

PARENT/GUARDIAN STATEMENT:

I hereby request that this medication be given to my child according to the physician's instructions. I agree to furnish the necessary medication in a pharmacy/original labeled container, to provide replacement medication as necessary, and to provide a new physician's statement if there is ANY change in the medication, dosage, administration time, administration route, or special instructions regarding the medication, I understand that other designated personnel (other than the school nurse) may give my child's medication or supervise the child with self-administration of the medication. I waive any liability claim against school staff assisting my child in taking medication.

Parent's/Guardian's Signature: _____ Date: _____

Asthma Action Plan

AMERICAN LUNG ASSOCIATION.

General Information:

■ Name _____

■ Emergency contact _____ Phone numbers _____

■ Physician/healthcare provider _____ Phone numbers _____

■ Physician signature _____ Date _____

Severity Classification		Triggers			Exercise
❍ Intermittent	❍ Moderate Persistent	❍ Colds	❍ Smoke	❍ Weather	1. Premedication (how much and when) _____
❍ Mild Persistent	❍ Severe Persistent	❍ Exercise	❍ Dust	❍ Air Pollution	_____
		❍ Animals	❍ Food		2. Exercise modifications _____
		❍ Other _____			_____

Green Zone: Doing Well

Peak Flow Meter Personal Best =

Symptoms

- ■ Breathing is good
- ■ No cough or wheeze
- ■ Can work and play
- ■ Sleeps well at night

Peak Flow Meter

More than 80% of personal best or _____

Control Medications:

Medicine	How Much to Take	When to Take It

Yellow Zone: Getting Worse

Contact physician if using quick relief more than 2 times per week.

Symptoms

- ■ Some problems breathing
- ■ Cough, wheeze, or chest tight
- ■ Problems working or playing
- ■ Wake at night

Peak Flow Meter

Between 50% and 80% of personal best or

_____ to _____

Continue control medicines and add:

Medicine	How Much to Take	When to Take It

IF your symptoms (and peak flow, if used) return to Green Zone after one hour of the quick-relief treatment, THEN

- ❍ Take quick-relief medication every 4 hours for 1 to 2 days.
- ❍ Change your long-term control medicine by _____
- ❍ Contact your physician for follow-up care.

IF your symptoms (and peak flow, if used) DO NOT return to Green Zone after one hour of the quick-relief treatment, THEN

- ❍ Take quick-relief treatment again.
- ❍ Change your long-term control medicine by _____
- ❍ Call your physician/Healthcare provider within ____ hour(s) of modifying your medication routine.

Red Zone: Medical Alert

Ambulance/Emergency Phone Number:

Symptoms

- ■ Lots of problems breathing
- ■ Cannot work or play
- ■ Getting worse instead of better
- ■ Medicine is not helping

Peak Flow Meter

Less than 50% of personal best or

_____ to _____

Continue control medicines and add:

Medicine	How Much to Take	When to Take It

Go to the hospital or call for an ambulance if:

- ❍ Still in the red zone after 15 minutes.
- ❍ You have not been able to reach your physician/healthcare provider for help.
- ❍ _____

Call an ambulance immediately if the following danger signs are present:

- ❍ Trouble walking/talking due to shortness of breath.
- ❍ Lips or fingernails are blue.

Rev. July 2008

ACCIDENT/INCIDENT REPORT

School: _____ Date (of occurrence):_____/ _____ /_____; Time: _____a.m./ p.m.

Name: _____ Gender: ☐ Male ☐ Female ☐ D.O.B.: _____

Street Address:_____ City/State:_____ Zip:_____ Phone: _____

Grade/Teacher (if student): _____ Title (if employee): _____

Parent or guardian notified (if student): _____

Family or friend notified (if employee): _____

Street Address:_____ City /State:_____ Zip:_____ Phone: _____

Location of accident/incident: ☐ Classroom ☐ Bus ☐ Gym ☐ Cafeteria ☐ Playground

☐ Steps ☐ Sidewalk ☐ Other: _____

Cause of accident: ☐ Collision with person ☐ Collision with obstacle (specify): _____
☐ Hit with projectile (specify): _____ ☐ Sudden turn, twist, or stop
☐ Fall (specify surface):_____ ☐ Fighting
☐ Other: _____
Description of how occurred: _____
Witness(es):_____ Teacher(s) on duty: _____

Body part(s) injured (note which side where applicable):

___ Abdomen:	☐ Left	☐ Right	___ Ankle	☐ Left	☐ Right	___ Clavicle:	☐ Left	☐ Right
___ Arm (upper):	☐ Left	☐ Right	___ Foot:	☐ Left	☐ Right	___ Shoulder	☐ Left	☐ Right
___ Arm (lower):	☐ Left	☐ Right	___ Knee:	☐ Left	☐ Right	___ Trunk:	☐ Left	☐ Right
___ Elbow:	☐ Left	☐ Right	___ Leg:	☐ Left	☐ Right	___ Back:	☐ Left	☐ Right
___ Finger:	☐ Left	☐ Right	___ Toe(s):	☐ Left	☐ Right	___ Eye(s):	☐ Left	☐ Right
___ Hand:	☐ Left	☐ Right	___ Hip(s):	☐ Left	☐ Right	___ Ear(s):	☐ Left	☐ Right
___ Wrist:	☐ Left	☐ Right	___ Groin:	☐ Left	☐ Right	___ Head	☐ Left	☐ Right

___ Other (specify) _____

Type of injury suspected (please check):
___ Bruise ___ Concussion ___ Dislocation ___ Fracture ___ Laceration
___ Sprain, Strain ___ Other (specify): _____

First aid or assistance provided (please check):

___ Cleansed wound with soap and water ___ Cleansed wound with saline

___ Applied ice ___ Applied compress ___ Controlled bleeding ___ Applied splint

___ Applied sling ___ Applied bandage, dressing ___ Immobilized ___ Other: _____

Further care:
___ Parent or relative took home ___ Parent or relative took to doctor

___ Ambulance transport ___ Parent or relative took to emergency room

___ Other (specify): _____

Absence due to accident/incident: _____
Comments: _____
Name of person reporting:_____ Title:_____ Date: _____
Nature of principal or administrator:_____ Date: _____
Follow-Up Remarks: _____
_____ Init./Date: _____

Student's Name_____Grade_____Homeroom_____
D.O.B_____Home Phone_____Emergency Phone_____
Student's Doctor_____Phone #_____Medicaid Yes_____No_____
ALLERGIES_____Is Epi Pen required? Yes_____No_____
Please circle below if your child has any of the following illness:

1.	HEART DISEASE	4.	BLIND	7.	ASTHMA	9.	HEMOPHILIA
2.	DIABETES	5.	DEAF	8.	PHYSICAL HANDICAP	10.	SEIZURES
3.	HYPOGLYCEMIA	6.	CANCER			11.	Any other health _____

12. Does your child war glasses? Full time_____Reading only
13. Does student receive Chemotherapy? Yes_____No_____
14. Any special nursing care or observation required during school nurse hours? Yes_____No_____
15. Any restriction on physical activity? Yes_____No_____ Explain _____
16. Medication student receives_____
17. Is inhaler required at school for asthma Yes_____No_____
18. I give permission of the following:
    1. Participate n school health programs Yes___No_____
    2. Receive first aid if needed Yes_____No_____
    3. Receive treatment for minor skin disorders. Yes_____No_____ (antifungal, calamine/calahist)
    4. Receive EMERGENCY CARE. Yes_____No_____
    5. Receive treatment for insect bites . Yes_____No_____ (sting Kill)
    6. To transport to local Hospital in case of emergency. Yes_____No_____

I always wave any liability claim against Lowndes County Schools in case of accident while transporting my child for medical attention.

_____ _____
Date Signature of parent or guardian.

AUTHORIZATION FOR SELF- ADMINISTRATION OF ASTHMA MEDICATION BY STUDENTS IN THE LOWNDES COUNTY SCHOOL DISTRICT

Revised 08/22/2013

I/We, the undersigned parent(s) or guardian(s) of _____, authorize the school/school district to permit my/our child to self-administer asthma medications. I/We understand this is my/our responsibility to provide the proper medication to my/our child, to insure that my/our child carries his/her medication with them, and that my/our child is properly instructed on the self-administration of the medication. I/We understand that a written statement must accompany this authorization form my/our child's health care practitioner verifying that he/she has asthma and has been instructed in self-administration of asthma medications. The statement must also contain:

1. The name and purpose of the medication
2. The prescribed dosage;
3. The times at which or circumstances under which the medications are to be administered;
4. The length of time for which the medications are prescribed;
5. The signature of the child's health care practitioner; and
6. The date the statement was signed.

RELEASE AND INDEMNITY AGREEMENT: I/We forever release, discharge and covenant to hold harmless the Lowndes County School District, its personnel, agents, employees, volunteers, and Board of Trustees from any/all liability claims, demands, damages, expenses, loss of services, and causes of action belonging to my/our child or to the undersigned arising out of or on account of any injury, sickness, disability, death, loss of damages of any kind resulting from self-administration of the asthma medicines except in cases of willful or wanton conduct.

_____ _____
Wi Parent/Guardian

_____ _____
Wi nt/Guardian

I/We agree to repay the school district, its personnel, agents, employees, volunteers, or Trustees any sum of money, expenses, or attorney's fees that any of them may be compelled to pay in defense of any action or any such injury or death to my/our child as a result of self administration of the asthma medicines except in cases of willful or wanton conduct.

I/We have read the foregoing release and indemnity agreement, and fully understand it. Executed this the _____ day of _____, 20__.

Katie Elliott, RN Lakeside Schools Ph- 566-2051 Fax- 328-2912	Kim Woodruff, R New Hope Schools Ph- 244-4760 Fax- 244-4775	Chanell Barnes, RN West Lowndes Schools Ph- 244-5050 Fax- 328-2912

**** CHILD REQUIRES ASSISTANCE IN ADMIN-**

TO BE COMPLETED BY THE PHYSICIAN

_____ has received instructions in the self-administration of _____
Patient's Name Medication

for asthma, and is to self-administer _____ of this medication at _____ .
Dosage Date/Time

SIDE EFFECTS: _____

TERMINATION DATE: _____ COMMENTS/CONDITIONS: _____

_____ _____
Name of Physician (Please Print) Signature of Physician

_____ _____
Telephone Number/Fax Number Street Address, City

FIRST AID TRAINING

Principals shall see that one-third of the instructional staff of the school is currently certified by the American Red Cross to administer first aid. All physical education teachers in the secondary schools shall be currently certified to give first aid.

CROSS REF.: Policies JGCD- Medicines
JGD- Safety During Instruction

Exhibits:

ACCIDENT REPORT

School_____ _____School's Phone #_____

Student's Name__ _____Phone #

Age _____ _____Sex_____Address

Date _____ _____Time___
_____Insurance

_____
Grade_____Teacher_
_____School

_____ _____

_____ Location of accident

Person in attendance

Nature of Accident Part of Body Injured

Abrasion
Head Injury
Abdomen
Eye*

Head
Bruise/
Burn Lac-
Cut Puncture
Convulsion Shock
~~Dislocation Sprain El~~
Other

Bump Fracture Ankle* Face Knee*
eration Arm* Finger* Leg*
Back Foot* Teeth
Check Hand* Wrist*
bow*

_____

_____
Other

_____

*Left, right, both

_____
How did it happen?

_____

_____

Were parents notified? Yes_____No_____Amount of time lost from school:

_____
Treatment and disposition: _____

_____

_____

LOWNDES COUNTY SCHOOL DISTRICT
Medication Authorization

Dear Dr._____:

The Lowndes County School District's policy regarding the dispensing of medication in school is that medication shall be administered only when the student's health requires it to be given during school hours. Medication administered at school must be in a properly labeled container or prescription bottle, and written authorization from the student's parent and physician is required. All medications will be kept in a locked cabinet in the office and will be administered by designated school personnel.

Sincerely,

_____
Lowndes County Superintendent of Education

_____ _____is to receive_____
(Patient) (Medication (Me _____
_____
(Time) (D
at ____ _____for
the _____ treatment of___
_____
_____
_____
(Na
Side Effects:
_____ Termination
date:
_____
Physi- cian's Address:
Physician's Tele- phone Number:

PARENTAL PERMISSION

PARENT/GUARDIAN STATEMENT:
I hereby request that this medication be given to my child according to the physician's instruction. I agree to furnish the necessary medication in a pharmacy/original labeled container, to provide replacement medication as necessary, and to provide a new physician's statement if there is ANY change in the medication, dosage, administration time, administration route or special instructions regarding the medication. I understand that other designated personnel (other than the school nurse) may give my child's medication or supervise the child with self-administration of the medication. I waive any liability claim against school staff assisting my child in taking medication

_____
(Parent/Guardian's Signature) (Date)