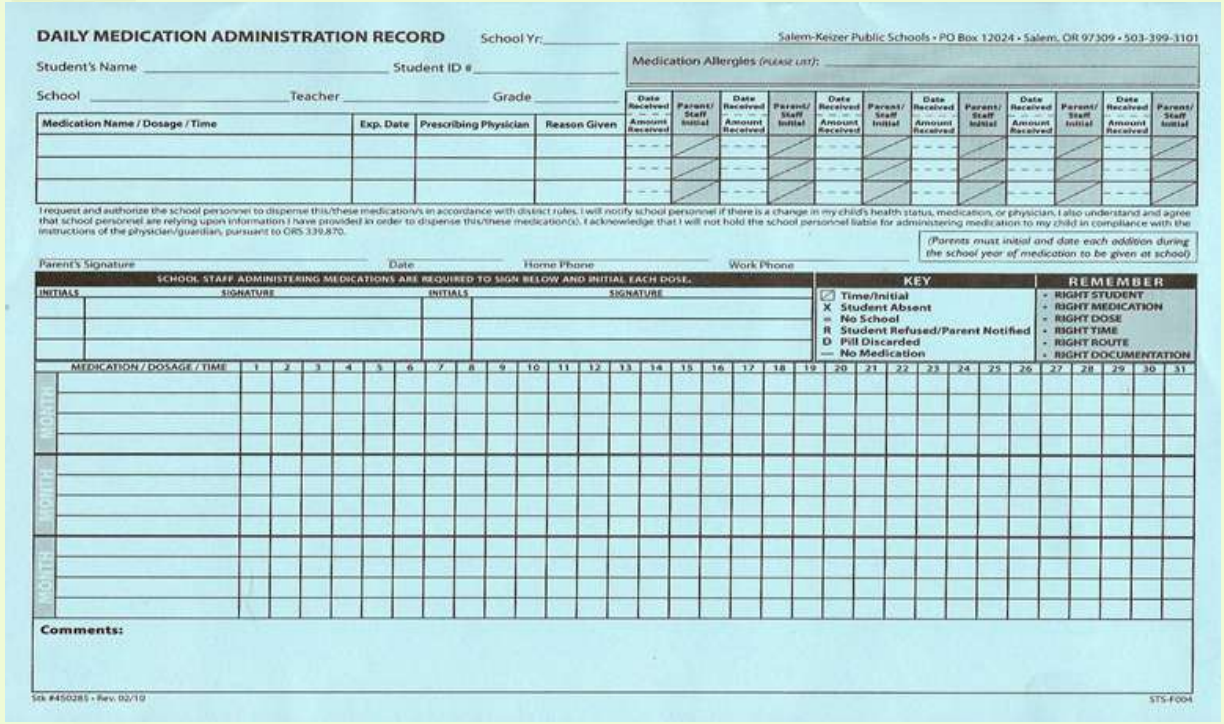
Health Services in Salem-Keizer Public Schools

Our School Health Nurses

- Identify students who are at risk for health emergencies
- Develop Health Management Plans for students
- Manage & care for students with Diabetes
- Provide consultation to schools during student contact days/hours through the “Nurse Helpline”
- Train school staff
- Train school staff
- Work with Marion & Polk County Health Departments

Medication Administration Process



DAILY MEDICATION ADMINISTRATION RECORD School Yr:

Salem-Keizer Public Schools • PO Box 12024 • Salem, OR 97309 • 503-399-3101

Student's Name _____ Student ID # _____

School _____ Teacher _____ Grade _____

Medication Allergies (PLEASE LIST): _____

Medication Name / Dosage / Time	Exp. Date	Prescribing Physician	Reason Given	Date Received / Amount Received	Parent/Staff Initial	Date Received / Amount Received	Parent/Staff Initial	Date Received / Amount Received	Parent/Staff Initial	Date Received / Amount Received	Parent/Staff Initial	Date Received / Amount Received	Parent/Staff Initial	Date Received / Amount Received	Parent/Staff Initial

I request and authorize the school personnel to dispense this/these medication/s in accordance with district rules. I will notify school personnel if there is a change in my child's health status, medication, or physician. I also understand and agree that school personnel are relying upon information I have provided in order to dispense this/these medication(s). I acknowledge that I will not hold the school personnel liable for administering medication to my child in compliance with the instructions of the physician/guardian, pursuant to ORS 339.870.

(Parents must initial and date each addition during the school year of medication to be given at school)

Parent's Signature _____ Date _____ Home Phone _____ Work Phone _____

SCHOOL STAFF ADMINISTERING MEDICATIONS ARE REQUIRED TO SIGN BELOW AND INITIAL EACH DOSE.

INITIALS	SIGNATURE	INITIALS	SIGNATURE

KEY

- ☑ Time/Initial
- X Student Absent
- = No School
- R Student Refused/Parent Notified
- D Pill Discarded
- — No Medication

REMEMBER

- RIGHT STUDENT
- RIGHT MEDICATION
- RIGHT DOSE
- RIGHT TIME
- RIGHT ROUTE
- RIGHT DOCUMENTATION

MEDICATION / DOSAGE / TIME	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
MONTH																															
MONTH																															
MONTH																															

Comments:

Stk #450285 • Rev. 02/10 STS-F004

Parents must complete the blue “Medication Administration Record” with:

- Name and dosage of medication
- Route of medication
- Frequency of administration
- Signs/symptoms for which medication is to be administered

Pupil Medical Records

SALEM•KEIZER PUBLIC SCHOOLS

PUPIL MEDICAL RECORD
Confidential information

STUDENT ID#	SCHOOL

Student's Name: Birthdate: Grade: Sex: M F

Parent/Guardian: Work PH: Home PH:

Email: Cell PH:

Name of Healthcare Provider/Clinic: Phone:

GUARDIAN'S EVALUATION OF STUDENT'S HEALTH

1. Has your student been **diagnosed** for any of the following? **If yes, please describe.**
   - ❑ ADD/ADHD
   - ❑ Allergy to:
     Is Epinephrine prescribed: ☐ Yes ☐ No
   - ❑ Asthma
   - ❑ Bladder Disorder
   - ❑ Blood Disorder
   - ❑ Bowel Disorder
   - ❑ Cancer *Date:*
   - ❑ Concussion/Head Injury *Date:*
   - ❑ Diabetes ☐ Type 1 ☐ Type 2 *Date of diagnosis:*
   - ❑ Ear Disorder
   - ❑ Eye Disorder
   - ❑ Food Intolerance to:
   - ❑ Heart Condition
     Has this condition been repaired? ☐ Yes ☐ No *Date of repair:*
     Any activity restrictions? ☐ Yes ☐ No *Describe restrictions:*
   - ❑ Seizure Disorder
   - ❑ Suppressed Immune System
   - ❑ Syndrome *Date of diagnosis* *Describe:*
   - ❑ Other health problem *Date of diagnosis:* *Describe:*
2. Does your student have a physical handicap? ☐ Yes ☐ No *Describe:*
3. Has your student ever had an operation? ☐ Yes ☐ No *Describe:*
4. Has your student ever had a severe injury? ☐ Yes ☐ No *Describe:*
5. Is your student presently under a healthcare provider's care for a particular illness or condition? ☐ Yes ☐ No
   State nature of illness or condition:
6. Is he/she taking medication? ☐ Yes ☐ No *Reason:*
   Name of medication:
   Note: An additional form must be completed for all medications taken at school
7. Is your student able to participate in full activity at school? ☐ Yes ☐ No
   List restrictions:
8. Has your student been hospitalized recently? ☐ Yes ☐ No *Date:* *Reason:*

PLEASE CALL THE NURSE HELPLINE AT (503)399-3376 IF YOU HAVE FURTHER QUESTIONS OR CONCERNS

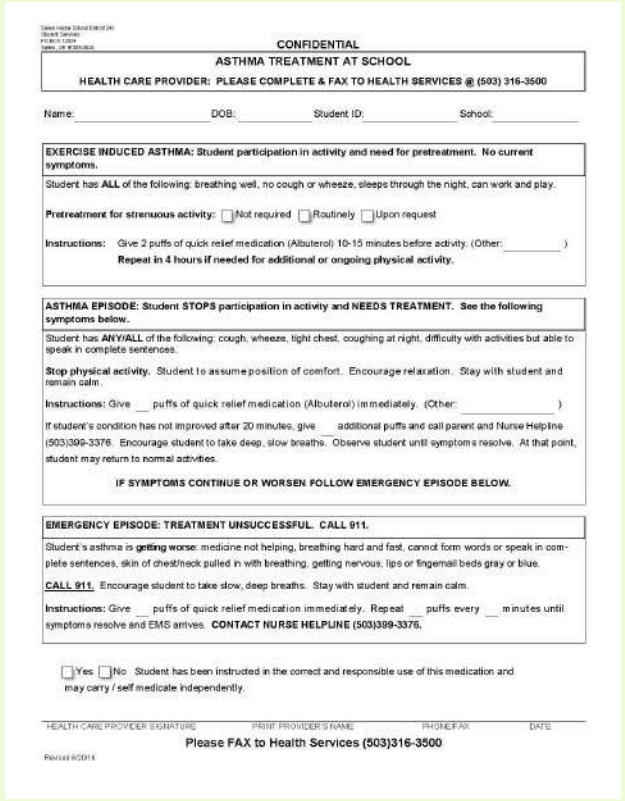
SIGNATURE OF PARENT/LEGAL GUARDIAN DATE

Revised 06/2016 Distribution: White: Oregon School Health Screening Record Yellow: Health Service

Parents should complete a PMR for each student:

- Enrolling in a Salem-Keizer school for the first time, including Kindergarten
- Entering 6th and 9th grade
- "Yes" is marked for a health condition on the student registration form
- Their student's health status changes
- Their student is taking medication at school

Asthma & Severe Allergy Treatment at School



CONFIDENTIAL

ASTHMA TREATMENT AT SCHOOL

HEALTH CARE PROVIDER: PLEASE COMPLETE & FAX TO HEALTH SERVICES @ (503) 316-3500

Name:_____ DOB:_____ Student ID:_____ School:_____

EXERCISE INDUCED ASTHMA: Student participation in activity and need for pretreatment. No current symptoms.

Student has **ALL** of the following: breathing well, no cough or wheeze, sleeps through the night, can work and play.

Pretreatment for strenuous activity: ☐Not required ☐Routinely ☐Upon request

Instructions: Give 2 puffs of quick relief medication (Albuterol) 10-15 minutes before activity. (Other:_____)
Repeat in 4 hours if needed for additional or ongoing physical activity.

ASTHMA EPISODE: Student STOPS participation in activity and NEEDS TREATMENT. See the following symptoms below.

Student has **ANY/ALL** of the following: cough, wheeze, tight chest, coughing at night, difficulty with activities but able to speak in complete sentences.

Stop physical activity. Student to assume position of comfort. Encourage relaxation. Stay with student and remain calm.

Instructions: Give __ puffs of quick relief medication (Albuterol) immediately. (Other:_____)

If student's condition has not improved after 20 minutes, give __ additional puffs and call parent and Nurse Helpline (503)399-3376. Encourage student to take deep, slow breaths. Observe student until symptoms resolve. At that point, student may return to normal activities.

IF SYMPTOMS CONTINUE OR WORSEN FOLLOW EMERGENCY EPISODE BELOW.

EMERGENCY EPISODE: TREATMENT UNSUCCESSFUL. CALL 911.

Student's asthma is **getting worse**: medicine not helping, breathing hard and fast, cannot form words or speak in complete sentences, skin of chest/neck pulled in with breathing, getting nervous, lips or fingernail beds gray or blue.

CALL 911. Encourage student to take slow, deep breaths. Stay with student and remain calm.

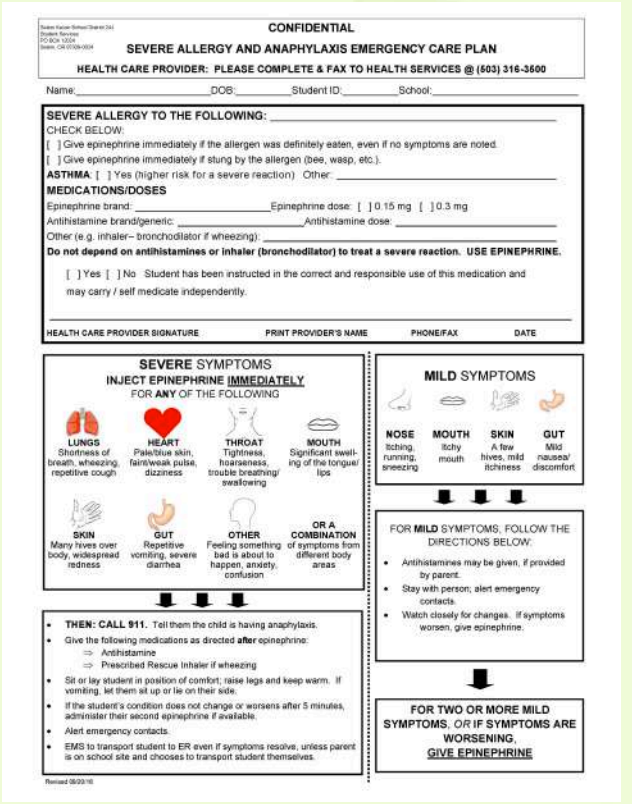
Instructions: Give __ puffs of quick relief medication immediately. Repeat __ puffs every __ minutes until symptoms resolve and EMS arrives. **CONTACT NURSE HELPLINE (503)399-3376.**

☐Yes ☐No Student has been instructed in the correct and responsible use of this medication and may carry / self medicate independently.

HEALTH CARE PROVIDER SIGNATURE PRINT PROVIDER'S NAME PHONE/FAX DATE

Please FAX to Health Services (503)316-3500

Revised 8/2018



CONFIDENTIAL

SEVERE ALLERGY AND ANAPHYLAXIS EMERGENCY CARE PLAN

HEALTH CARE PROVIDER: PLEASE COMPLETE & FAX TO HEALTH SERVICES @ (503) 316-3500

Name:_____ DOB:_____ Student ID:_____ School:_____

SEVERE ALLERGY TO THE FOLLOWING: _____

CHECK BELOW:

[ ] Give epinephrine immediately if the allergen was definitely eaten, even if no symptoms are noted.

[ ] Give epinephrine immediately if stung by the allergen (bee, wasp, etc.).

ASTHMA [ ] Yes (higher risk for a severe reaction) Other: _____

MEDICATIONS/DOSES

Epinephrine brand: _____ Epinephrine dose: [ ] 0.15 mg [ ] 0.3 mg

Antihistamine brand/generic: _____ Antihistamine dose: _____

Other (e.g. inhaler– bronchodilator if wheezing): _____

Do not depend on antihistamines or inhaler (bronchodilator) to treat a severe reaction. USE EPINEPHRINE.

[ ] Yes [ ] No Student has been instructed in the correct and responsible use of this medication and may carry / self medicate independently.

HEALTH CARE PROVIDER SIGNATURE PRINT PROVIDER'S NAME PHONE/FAX DATE

SEVERE SYMPTOMS

INJECT EPINEPHRINE IMMEDIATELY

FOR **ANY** OF THE FOLLOWING

LUNGS Shortness of breath, wheezing, repetitive cough

HEART Pale/blue skin, faint/weak pulse, dizziness

THROAT Tightness, hoarseness, trouble breathing/ swallowing

MOUTH Significant swelling of the tongue/ lips

SKIN Many hives over body, widespread redness

GUT Repetitive vomiting, severe diarrhea

OTHER Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas

- **THEN: CALL 911.** Tell them the child is having anaphylaxis.
- Give the following medications as directed **after** epinephrine:
  - ⇨ Antihistamine
  - ⇨ Prescribed Rescue Inhaler if wheezing
- Sit or lay student in position of comfort, raise legs and keep warm. If vomiting, let them sit up or lie on their side.
- If the student's condition does not change or worsens after 5 minutes, administer their second epinephrine if available.
- Alert emergency contacts.
- EMS to transport student to ER even if symptoms resolve, unless parent is on school site and chooses to transport student themselves.

MILD SYMPTOMS

NOSE Itching, running, sneezing

MOUTH Itchy mouth

SKIN A few hives, mild itchiness

GUT Mild nausea/ discomfort

FOR **MILD** SYMPTOMS, FOLLOW THE DIRECTIONS BELOW:

- Antihistamines may be given, if provided by parent.
- Stay with person; alert emergency contacts.
- Watch closely for changes. If symptoms worsen, give epinephrine.

FOR TWO OR MORE MILD SYMPTOMS, *OR* IF SYMPTOMS ARE WORSENING, GIVE EPINEPHRINE

Revised 08/2016

Before & After School Activities and Programs

It is the parent's responsibility to:

- Inform "Before & After School" activities and programs of student health needs
- Provide separate permission forms, supplies, and medications
- Consult with the program director regarding specific health and safety needs

Head Lice

- We recommend parents monitor their students for head lice
- A common symptom of infestation is an itchy scalp behind ears or back of the neck
- Students with **live lice** will be excluded at the **end of the school day**
- **Treatment for live lice is required**
- A parent is to accompany their student to the office for a head check before returning to school

Dental Screening Certificates

- The Dental Screening Certificate is a part of your student's registration packet
- Dental Screening Certificates are not an "opt out" to any actual dental screening which may occur at your student's school
- A separate form will be sent home to "Opt-out" of any dental services being offered at your student's school

Vision Screenings

- Vision screenings for your student are completed by the Oregon Lions Foundation
- Families will be notified of the date and time of the school's vision screening with instructions on how to "opt out", if desired

Immunizations

- Students must have **<u>one of each</u> of the following vaccinations BEFORE initial enrollment**
  - Measles, mumps, rubella (MMR), Polio, Diptheria, Tetanus, Hepatitis B, Varicella (chickenpox)
- Parents must complete an Oregon Certificate of Immunization Status form included in the registration packet
- Certification for non-medical exemptions are available only through:
  - Your student's health care provider
  - www.healthoregon.org/vaccinationexemption

When Should Students Stay Home?

- Fever greater than 101 F
- Vomiting
- Stiff neck or headache with fever
- Any rash with fever or behavior change, until a physician has determined that the illness is not a communicable disease
- Unusual behavior change
- Jaundice
- Diarrhea
- Skin lesions that are “weepy”
- Colored drainage from eyes
- Brown/green drainage from nose with fever of greater than 101 F
- Difficulty breathing or shortness of breath; serious sustained cough
- Symptoms/complaints that prevent student from participating in his/her usual school activities

Health & Safety Tips

- Healthy, balanced diet
- Sleep
- Closed-toed shoes
- Screen time
- Keep “Emergency Contact” information current

References

2015 ORS 339.870¹ Liability of school personnel administering medication. (n.d.). Retrieved April 10, 2017, from https://www.oregonlaws.org/ors/339.870

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