Welcome to Central High School Nurses' Office!

What forms does your child need to attend Central High School?

Required documentation is due no later than September 4, 2020.

- S865 - Student Emergency/Medical Information form
- MEH 1 – Report of Physical Examination
- Immunizations
- MED 1 – Request for Administration of Medication
    - Only necessary for conditions that require medications to be taken in school (this includes diabetes medication and supplies, asthma inhalers, and EPI-pens. Students may self-carry these medications and may also keep a supply in the nurses' office).

What else do you need to know about the nurses' office?

- Students must have a hall pass signed by their teacher to see the school nurse.
- If a student visits the nurse, they may potentially need to be dismissed from school.
    - Students will **NOT** be permitted to leave on their own, they must be signed out by an adult designated on an Emergency Contact form. Please be sure to list any and all adults that might be available to pick up your child during the school day.
- Students who become ill or injured at home should seek care from their primary care provider.
    - Fever greater than 100°F should stay home until they are fever free for 24 hours without using fever reducing medications
    - Students who need to use the elevator must submit medical documentation to the nurses' office.

The only over the counter medications in the nurses' office are acetaminophen, ibuprofen and hydrocortisone cream. All others require an MED1. Nurses are prohibited from keeping any other medications including allergy, cold, and stomach medicines. See attached medication policy.

The nurses are here to keep your child as healthy as they can be! However, there are occasions when illness or injury occur in school. In order to accomplish all of our goals, the school nurses will adhere to the following schedule:

Homeroom:	Issuance of elevator passes for students who arrive at school with a recent orthopedic injury and acceptance of medical documentation.
9:00-11am:	Health Screenings, student health management, and documentation.
11am-12pm:	Nursing care of students who become ill or sustain minor injuries **during school hours**.
12pm-1pm:	Lunch and Documentation
1pm-2pm :	Nursing care of students who become ill or sustain minor injuries **during school hours**.
2pm-3:04pm:	Student health management and documentation.

Emergencies will be seen at any time.
(ex: TROUBLE BREATHING, CHEST PAIN, VOMITING, BLEEDING, SERIOUS INJURY)

Questions? Please contact us!

Rodney Abary, CRNP
rabary@philasd.org

Leigh A. Coakley, RN
lcoakley@philasd.org

Alma Kokthi, RN
akokthi@philasd.org

Parent complete

THE SCHOOL DISTRICT OF PHILADELPHIA

Student Emergency /Medical Information

Last Name:_____First Name:_____DOB: _____

School:_____Room/Sec:_____Grade:_____

_

Home Address: _____ Home phone: _____

Mother: _____email: _____phone: _____

Father: _____email: _____phone: _____

Guardian: _____email: _____phone: _____

Emergency contacts (other than parents) must be local and available for contact:

Name and Relationship to child **Phone**

1._____

2._____

Childs Doctor/Clinic: _____Phone:_____

Medical Insurance: MA___ CHIP____ Private_____

Insurance company name: _____ Policy Number_____

Please circle below to give permission to the school nurse to give your child medication.

Acetaminophen(Tylenol)	Yes	No
Ibuprofen (Motrin)	Yes	No

Please **CIRCLE** the following if your child:

Wears: Glasses Hearing aid

Has: Seizures Diabetes Asthma ADHD

List Allergies: Food substitution requires a new order yearly from a health care provider: _____

_____

Other Health Problems: _____

_____

_____

Does your child take medication? ____NO ____YES (please list)

Medication	Dose	Frequency/Time	Reason

Your signature gives permission for emergency treatment; as well as for SDP School Nurses to administer medications you indicate on this emergency form, during school hours, on field trips and after school activities.
I authorize the school nurse to communicate with my child's health care provider and my health care provider to reply as needed regarding my child's care.

_____

Doctor complete. May attach electronic form.

THE SCHOOL DISTRICT OF PHILADELPHIA
SCHOOL HEALTH SERVICES

REPORT OF PHYSICAL EXAMINATION

Name of Student	Date of Birth	Student ID #	Grade
Name of School	Room/Section/Book	Date Issued	

TO THE PARENT/GUARDIAN:

I authorize the school nurse to communicate with my child's health care provider and my health care provider to reply as needed regarding my child's care.

Parent/Guardian Signature_____Date_____

RECORD OF VACCINE ADMINISTRATION

Please attach complete immunization record including serology results if available.

■ Allergies_____ ■ Date of last PPD_____Result_____mm

Does this student have health insurance?_____Yes_____No Name of Insurance Provider:_____

RECORD THE FOLLOWING

1. Visual Acuity: Without Glasses: R_____ L_____ With Glasses: R_____ L _____

2. Audiometric Screening: R_____ L _____ 3. BP _____

4. Height_____inches / cm Weight_____lb. / kg BMI percentile _____

5. Scoliosis Screening: _____Normal _____Abnormal _____Referred _____No Referral

6. Activity Recommendation:_____Full Physical Activity _____Restricted Physical Activity
(Must Complete Phys. Ed. Medical Exemption/Program Modification Form MEH-23)
Specify Restrictions: _____

7. List all medications currently being taken:

Medication:_____Reason:_____

8. List ALL problems by history or examination:

	Circle status of problem		
1. _____	Under Care	Care Complete	Referred
2. _____	Under Care	Care Complete	Referred
3. _____	Under Care	Care Complete	Referred

_____ No Problems Identified

Comments / follow-up treatment plan / Special instructions to school:

Signature of Care Provider (REQUIRED)	Telephone Fax	Care Provider office stamp (REQUIRED)
Address	Date of Exam	

SCHOOL DISTRICT QF PHILADELPHIA

CENTRAL HIGH SCHOOL

IMMUNIZATION RECORD

NO student will be admitted with an incomplete immunization record per the State of Pennsylvania and may be sent home the first day of school by the school nurse.

_____ _____ _____

Name Current School M.I.

_____ _____ _____

Date of Birth ID Number Room/Book

IMMUNIZATIONS REQUIRED (may attached printed record):

VACCINE Circle appropriate item	Enter month, day, and year when immunization doses listed below were given.				
Diphtheria, tetanus and acellular pertussis (DTaP, DTP, Td or DT)	1 / /	2 / /	3 / /	4 / /	5 / /
Tetanus, diphtheria and acellular pertussis (Tdap)	1 / /	2 / /	3 / /	4 / /	5 / /
Polio (OPV or IPV)	1 / /	2 / /	3 / /	4 / /	5 / /
Hepatitis B	1 / /	2 / /	3 / /	4 / /	5 / /
Measles - mumps - rubella (MMR)	1 / /	2 / /	or Measles serology Date		Titer
Varicella (vaccine or disease)	1 / /	2 / /	Rubella serology Date		Titer
Meningococcal (MCV)	1 / /	2 / /			
Other	1 / /	2 / /	Mumps disease diagnosed by a physician: Date		

One dose of DTaP must be on or after the fourth (4th) birthday.
One dose of Polio must be on or after the fourth (4th) birthday.
First doses of MMR and Varicella must be on or after the first (1st) birthday and the second dose should be at least one month after the first dose.

Children not immunized must provide an immunization exemption form available from your school nurse or the School District website.

_____ _____ _____

Date Signed Doctor's Signature Doctor's Phone Number

_____	_____	_____
Date Signed	Parent or Guardian Signature	Home Phone

THE SCHOOL DISTRICT OF PHILADELPHIA

SCHOOL HEALTH SERVICES

REQUEST FOR ADMINISTRATION OF MEDICATION, TREATMENTS OR USE OF EQUIPMENT IN SCHOOL

(PLEASE SEE MESSAGE TO PHYSICIAN AND PARENT ON BACK OF FORM)

PHYSICIAN, PLEASE NOTE: Fill in all of the spaces. Missing information will cause the form to be returned to you. This will cause a delay in your patient receiving medication / treatment. A separate request is needed for each medication.

NAME OF PATIENT/STUDENT	ADDRESS/ZIP	ROOM/BOOK NO.

DATE OF BIRTH	SCHOOL/ORG.#	REGIONAL OFFICE	PID

DIAGNOSIS:

REASON MEDICATION MUST BE GIVEN IN SCHOOL:

NAME OF MEDICATION/EQUIPMENT/TREATMENT:	DOSE:

TIME(S) TO BE GIVEN IN SCHOOL:	TOTAL DOSAGE PER 24 HRS:

DATE BEGIN:	DATE END:

INSTRUCTION FOR ADMINISTRATION/UTILIZATION:

CONTRAINDICATIONS:

SIDE EFFECTS:

TREATMENT OF SIDE EFFECTS/ACTION TO BE TAKEN:

IS ANY RESTRICTION ON ACTIVITY NECESSARY: YES ☐ NO ☐

IF YES, DESCRIBE:

IS STUDENT TAKING ANY OTHER MEDICATION? YES ☐ NO ☐

IF YES, NAME OF MEDICATIONS:

IS SIMILAR EQUIPMENT KEPT BY THE CHILD'S FAMILY AT HOME? YES ☐ NO ☐

PRINT NAME OF HEALTH CARE PROVIDER/CREDENTIALS	TELEPHONE
ADDRESS	EMERGENCY NUMBER
SIGNATURE OF HEALTH CARE PROVIDER	DATE SIGNED

To The Principal

- I authorize the certified school nurse to administer the indicated medication, or to use the equipment or machinery as prescribed by my child's health care provider, whose signature appears on this form.
- My child may self-administer medication/equipment as determined appropriate by the school nurse.
- I authorize the school nurse to communicate with my child's health care provider and my health care provider to reply, as needed, regarding this medication/ equipment and/or my child's response.

PARENT SIGNATURE _____ TELEPHONE NUMBER _____

DATE SIGNED _____ EMERGENCY NUMBER _____

IN ACCORDANCE WITH CURRENT SCHOOL DISTRICT PROCEDURE

- I have assessed this student and he/she has demonstrated competency and may self administer this medication/treatment (__) yes (__) no
- The administration of this medication/treatment was approved on: _____ DATE

SIGNATURE OF SCHOOL NURSE _____

TELEPHONE NUMBER OF SCHOOL NURSE _____

Doctor complete. Parent sign.
Only required for students who need prescription medication while in school.

MED-1 (Rev. 6/2018)

DISTRIBUTION OF COPIES: SCHOOL NURSE- KEEPS ORIGINAL; PARENT- KEEP COPY

TO THE PHYSICIAN:
Your patient has requested that medication be administered in school. Ideally, the administration of medication should take place at home. However, for students who require medication during the school day in order to function in the classroom, School District Policy does permit licensed school staff to administer medication. In some cases, students may self-administer their medication.

IF YOUR PATIENT'S MEDICATION CANNOT BE ALTERED SO THAT ALL ARE RECEIVED AT HOME, PLEASE COMPLETE THE REQUEST ON THE REVERSE SIDE· A SEPARATE REQUEST IS REQUIRED FOR EACH MEDICATION OR TREATMENT.

Please fill in all of the spaces. Missing information will cause the form to be returned to you. This will cause a delay in your patient receiving medication/treatment.

Thank you.

School Health Services

DEAR PARENT/GUARDIAN:

Some children need the administration of medication in order to function in the classroom. Ideally, this should take place at home. If your child's medication schedule cannot be altered and administered at home, you can request the medication to be given in school by seeing the school nurse.

Once the School Nurse has approved the request, you will be required to bring the medication to school properly labeled and packaged by a Registered Pharmacist. The medication bottle must have Saf-T-Closure Cap and the label must include:

- Patient Name
- Pharmacy Name
- Pharmacy Address and Phone#
- Prescription Number
- Prescription Date (current)
- Name of medication, dosage form, expiration date (if relevant)
- Instructions for administration
- Name of prescribing health care provider

This procedure must be repeated each school year and/or each time there is a change in dosage.

Parents/guardians must pick up unused or expired medication in person, or send an authorized responsible adult with a note from you. Unused medication which is not picked up within 10 days, or by the last day of school, will be destroyed/discarded.

If you have any questions on this procedure, please contact the school nurse.

. Thank you.

THE SCHOOL DISTRICT OF PHILADELPHIA
CENTRAL HIGH SCHOOL
1700 WEST OLNEY AVENUE
PHILADELPHIA, PENNSYLVANIA 19141

TELEPHONE (215) 400-3590
FAX (215) 400-3591

Policies for Students Receiving Medication in School

- **All children receiving prescribed medication in school *must* have a completed MED-1 form** (Request for Administration of Medication) **on file for the current school year.** This includes children who need to have inhalers in school to be used as needed for asthma as well as EpiPens for allergies.

- **Prescribed medication *must* be in the proper packaging.** The package must clearly display the student's name, the name of the medication, instructions for administration, and the date the prescription was filled. **Medications delivered in inappropriate bottles or packaging will not be accepted.**

- **The person delivering the prescribed medication to school must sign the MED-4** (Medication / Equipment received in School) **Log** located in the Nurses office

- Prescribed medications will be administered by the School Nurse as directed. In the event that the nurse is not present, a nurse from another school may be administering the medication. In some cases, the parent may be asked to administer the prescribed medication if a nurse is unavailable or if a current MED-1 form is not on file for the current school year.

- Children who have medical conditions that require that they carry their own prescribed medication will be individually assessed to determine their eligibility to do so.

- **Please try to refrain from sending over-the-counter medications** (such as cough medicine, pain relievers, vitamins, etc…) **to school with your child unless absolutely necessary.**

- Acetaminophen(Tylenol) or Ibuprofen (Advil, Motrin) can be given by the School Nurse only if a completed S-865 (Student Emergency / Medical Information) form has been signed by a parent/guardian and submitted to the Nurses' office. These medications will not be given after 2:00pm.

If you have any questions or concerns, please contact the Nurses' office at 215-400-3590 extension 2. Thank you very much and have a nice day!