Turner USD 202
School Nurse Policy and Procedure Manual

2024-2025

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School Nursing Quick Reference Guide

A nurse is on duty as a service to students and staff. Students must have a written pass to visit the nurse for non-emergencies.

Illness Guidelines

- Fever of 100.0 or Higher: Send home and not to return to school unless fever free for 24 hours without the use of fever reducing medication (Tylenol, ibuprofen).
- Vomiting and/or Diarrhea: Send home and not to return unless free of symptoms for 24 hours.
- Strep Throat: Must be on antibiotics for 24 hours before returning to school
- Hand/Foot/Mouth disease or Impetigo: May return once fever free for 24hrs and blisters are dried up or per doctor's note.
- Pink Eye: Student will be sent home for signs of pink eye. May return once on antibiotic eye drops for 24 hours.
- Lice: Send home for live lice only. If only nits are present, student may stay in class.
- COVID: Follow CDC guidelines. No quarantine required at this time. May return to school if student has been fever free for 24 hours or date provided by doctor's note.
- RSV: May return once fever free for 24 hours or per doctor's note.
- Influenza: Remain out of school for 5 days following the onset of symptoms or positive test/diagnosis if they are asymptomatic.
- Head injuries: Always notify parent/guardian of a head injury no matter how minor.
- Possible breaks/sprains/strains: Always call to notify parent of possible injury. Any doubt send them home.
- Cuts: If superficial, rinse and clean, apply dressing. If any questions as to the depth of the wound or possibility of stitches, call parent and send home.
- Splinter: Do Not Remove. Clean with soap and water and apply band aide. We are unable to remove splinters since we have no way of sterilizing the needle.

Medically Excused Attendance

If the school nurse sends a student home it will be marked as medically excused.
If a parent called the student in and provides a doctor's note, the note must list the date(s) the student was physically unable to attend or was seen by the doctor.

Medication

<u>Prescription Medication</u>
All student prescription medication must be registered with the nurse. It must come in the original bottle with the child's name, dosage, and frequency on the bottle. A permission slip

must be signed by a parent/guardian and the prescribing doctor. These forms must be filled out each school year or if prescription changes.

Non-Prescription Medications

Over the counter medicine brought without a prescription must be registered with the nurse. A permission slip must be signed by a parent/guardian. Medication must be in its original container. No medicine sent in a plastic bag or other container will be accepted.
All medicine sent to school must be kept in the nurse's office. The ONLY exception is for inhalers when a doctor's note is on file stating that the student must carry it throughout the day.

All medicine must be dropped off and picked up by a parent or guardian. Students may not possess prescription medicine at school (See Policy JDDA). The only exception is inhalers. All medicine not picked up by the last day of the school year will be discarded.
If any student is transferring schools within the Turner School District, the Parent must pick up and transfer the medication themselves. The school nurse is not to transfer medication.

Notice to Parents

The health department will contact the district if there is an outbreak of any illness or disease. At that time, we will send notifications of the outbreak home to families of students. Depending on the type of outbreak, students with religious exemptions will follow the required exclusion period
To notify the Wyandotte County Health Department of a reportable disease, call 913-573-6712 (8am-5pm) or 913-573-8877 (after hours). You can also fax reports to 913-573-6744.

Physicals (Board Policy JGC)

Required students to turn in one physical to the school up to the age of 9. If a student has transferred schools within the state of Kansas, nurse is not required to ask for a physical. If the student has transferred schools from another state, parent/guardian is required to provide a physical. If the student is transferring from another country, no matter the age, parent/guardian is required to provide a physical. Parents have up to 90 days from the student's first day of enrollment to provide physical before exclusion from school.

Pregnant Student (Board Policy JQF)

Be aware of emergency contacts, due date, hospital student is to deliver at, and doctor information.

Screenings (Board Policy JGCD)

Vision

The schedule followed by Turner USD 202 is:

- All new students
- All teacher, parent, and student referrals
- All special education students and students with handicapping conditions
- All students in PK, K, 1st,2nd, 3rd, 5th, 7th and 10th grades

Hearing Screening

The schedule followed by Turner USD 202 is:

- All new students
- All teacher, parent, and student referrals
- All special education students and students with handicapping conditions
- All students in PK, K, 3rd, 6th, 9th and 12th grades

Suspect Student Under the Influence

Notify administration as soon as possible. Make sure student is stable and assess appropriately before further steps are taken.

Administrative Procedures

Absences

In the event of an absence, the school nurse should enter their absence in Frontline and notify the Department Chair as soon as possible. The Department Chair will keep a calendar of absences that will be shared with school nurses and the district float nurse for coverage purposes. If the float nurse is unable to cover an absence, nurses may be pulled from their building to assist with coverage. MTE, TMS, and THS will take priority in ensuring there is a nurse available.

Building Schedules

School	Report Time	Dismissal
Junction Elementary / JSOC	7:30 AM	3:30 PM
Midland Trail Elementary	8:10 AM	4:10 PM
Oak Grove Elementary	8:10 AM	4:10 PM
Turner Elementary	7:30 AM	3:30 PM
Sixth Grade Academy	7:30 AM	3:30 PM
Turner Middle School	7:00 AM	3:00 PM
Turner High School	7:00 AM	3:00 PM

**The district float nurse will be located at THS. The float nurse will be responsible for covering buildings in the event of an absence. The float nurse will adhere to the schedule of the building they are covering.*

Delegation of Responsibilities

The Director of Special Services may delegate nursing responsibilities to school nurses within the district.

Disposal of Bio-Hazards

Bio-hazardous material will be disposed of, by using Stericycle containers provided to each Nurse/building. Return full container to Stericycle, Inc., according to Mail back Program directions.

Disposal of Medications

Medications that are out of date or have been discontinued should be picked up by the parent/legal guardian. All medications should be picked up at the end of each school year. Parental/legal guardian notifications should be sent home at these times. When medications are not picked up after parent/legal guardian notification, they should be destroyed and that process should be witnessed and documented. Dispose of medications following procedures according to Federal Guidelines for "Proper Disposal of Prescription Drugs." https://www.ojp.gov/pdffiles1/ondcp/prescrip_disposal.pdf

Guidelines for Drug Disposal

FDA and the White House Office of National Drug Control Policy developed federal guidelines that are summarized here:

- Follow any specific disposal instructions on the prescription drug labeling or patient information that accompanies the medicine. Do not flush medicines down the sink or toilet unless this information specifically instructs you to do so.
- Take advantage of community drug take-back programs that allow the public to bring unused drugs to a central location for proper disposal. Call the city or county government's household trash and recycling service to see if a take-back program is available in your community. The U.S. Drug Enforcement Administration, working with state and local law enforcement agencies, periodically sponsors National Prescription Drug Take-Back Days.
- If no disposal instructions are given on the prescription drug labeling and no take-back program is available in your area, throw the drugs in the household trash following these steps.
    1. Remove them from their original containers and mix them with an undesirable substance, such as used coffee grounds or kitty litter (this makes the drug less appealing to children and pets, and unrecognizable to people who may intentionally go through the trash seeking drugs).
    2. Place the mixture in a sealable bag, empty can or other container to prevent the drug from leaking or breaking out of a garbage bag.

Ilisa Bernstein, Pharm.D., J.D., FDA's Deputy Director of the Office of Compliance, offers some additional tips:

- Before throwing out a medicine container, scratch out all identifying information on the prescription label to make it unreadable. This will help protect your identity and the privacy of your personal health information.
- Do not give your medicine to friends. Doctors prescribe medicines based on a person's specific symptoms and medical history. A medicine that works for you could be dangerous for someone else.
- When in doubt about proper disposal, talk to your pharmacist.

Bernstein says the same disposal methods for prescription drugs could apply to over-the-counter drugs as well.

http://www.fda.gov/forconsumers/consumerupdates/ucm101653.htm#guidelines

Growth and Development / Human Sexuality Curriculum (BOE Policy IKCA)

The school nurses may collaborate with the principal, classroom teacher, health teacher, PE teacher and the WYCO Health Department to present curriculum related to growth and development. Due to the sensitivity of this topic, nurses will provide a link of the video to be

shown to the parents upon request.

Each building will determine the appropriate process for informing parents of the ability to review visuals and/or other resource materials. Each year prior to presenting the growth and development curriculum, a permission letter will be sent home with parents outlining when and what curriculum will be presented to their child. It is recommended the staff review Kansas State Department of Education Standards in Science to assist in the integration of curriculum as appropriate.

Health Care Programs for Kansas Children

The school nurse is encouraged to remain knowledgeable of health care services available to children in Kansas who qualify according to specified criteria such as family income. KanCare is the State of Kansas program offering health insurance to children and teens. The School District participates in Medicaid reimbursement for children on Individual Education Plans with records maintained by the Special Services office. A non-special education program is referred to as Administrative Services Claiming (ASC). As a Medicaid reimbursement program, ASC requires staff to provide information to families, as appropriate, the preventative health services available through Medicaid. The school nurses as well as other support staff participate in a random sampling process which defines the amount of reimbursement available to the district.

Journey School of Choice (JSOC)

- School nurse located at Junction Elementary assigned to JSOC and available as needed
- Maintain JSOC student health records, ensuring all students meet minimum requirements of the immunization law and reflect current screening data
- Offer appropriate screening to all students enrolled in the Journey School of Choice
- Organize health records to allow accessibility to JSOC staff (principal)

Notice to Category I* Employees-Hepatitis B

The Turner School District provides the Hepatitis B vaccination series (3 immunizations over several months) to any employee of the District who may have occupational exposure and falls within Category I of the exposure determination.

*Category I employees are exposed to a specific hazard as a regular part of their job.

If the Category I employee wants to receive the immunization at the WCHD facility, the District must notify staff at WCHD. (See Employee Hepatitis B Form)

If any employee is exposed on the job, he/she may begin the vaccination series at that time at no charge, through Workman's Compensation.

Nurse Evaluation Process

Certified school nurses will be evaluated using an instrument approved as part of the certified staff negotiated agreement and is similar in design to the teacher appraisal process.

A classified school nurse will be evaluated using the classified employee evaluation form through Frontline.

Nurse Substitute

Qualifications

A school nurse substitute will be a registered nurse or a licensed practical nurse. Substitute nurses will be employed when available to replace the regular school nurse when the regular nurse must be out.

Preparing for a Substitute

The regular school nurse will prepare a substitute nurse folder that will be marked and placed on top of the nurse's desk. An example of the handbook is available for the school nurse review. Items that should be included in the folder and kept updated are:

- List of students with chronic health problems
- List of students currently on medications, location of medication, special procedures for giving medication, and location of medication sheets.
- Name of principal and secretary to who substitute will report any unusual or serious events.
- Director of Special Services office number 913-288-4181
- List of two other school nurses, substitute may call for consultation
- Any extra assignments or duties substitute is expected to perform
- Any procedures particular to that school
- Location of school Crisis Plan

Nurse Qualifications

A school nurse should possess a high degree of self-discipline, organizational skills, integrity, and a pleasing personality. A school nurse is a registered professional nurse in the State of Kansas. A licensed practical nurse (L.P.N.) will be considered as appropriate. The school nurse job description is available through the Human Resources department.

Philosophy

The school health program is established and implemented to assist the educational process by

promotion of optimal health. The health program is coordinated with the total health school program, and is designed to assist with adaptation for the individual student when health obstacles interfere with learning. The intent is to promote, protect, and maintain the health of the students so that quality education may be achieved.

Schedule of Activities

Daily:

- Student visit recorded on Daily Log in Infinite Campus
- Medication administration records in Infinite Campus
- Student Education Immunization review
- Care plan implementation
- Incident reports completed and turned in
- Keep your Time and Effort Log up to date
- Exclusion/Admission of student with communicable diseases
- Assess wellness
- Administer first aid
- Meal planning coordination: Alert Kitchen Staff
- Obtain Health records of transfer students
- Food Allergies
- Complete Medicaid billing in Greenbush activity log for eligible students

Weekly:

- Send copy of employee and or student incident reports to the Director of Special Services, and the Director of Business Services.
- If an employee is sent to KU Corporate Health/Benefits Coordinator, send copy of incident report to the Benefits Coordinator

Monthly:

- Vision and Hearing on new students
- Immunization audit and letters sent
- Care plan review
- Turn Time and Effort Logs into the Secretary of Special Services
- Send AED Log the first of each month to the Special Services Secretary
- Web IZ with immunization audit (perform as needed)

Annually:

- Open nurse's office-place supplies in convenient, easily accessible area (August)
- Screenings
- Check in equipment to Special Services Secretary
- Close nurse's office-secure all equipment/supplies to accommodate annual cleaning (May)
- Student Care Plans (August)
- Check www.kdheks.gov/immunize for current year requirements. (August)

- Hearing Screenings begin before May 1st
- Vision Screenings begin before May 1st
- List of staff trained CPR/First Aid to your principal (August)
- Send home Immunization Forms/Physical order for next year (April, May, July)
- Send notes home to parents to pick up medications. (May)
- Growth and Development Videos (March) Wyandotte County Health Department
- Medical information and meds needed for Summer School Students (May)
- Annual Health form to students updated and filed
- Take off the months from hearing and vision screening.
- Student health care plans and Classroom action plans (August)

School Health Programs

Important elements of the school health program include immunization surveillance, hearing screening, vision screening, health screening, and dental program evaluation and follow up of all health problems, health education, communicable disease control, and growth and development. The nurse shall assist with mass hearing screening in the fall. Teacher-nurse conferences and parent-nurse conferences should be held periodically at the school. An important element in the care of school age is follow- through and is important and careful documentation is necessary to ensure continuity of care and quality assurance.

Student Care

Child Abuse and Neglect Identification

The report of suspected child abuse will be made by phone to a member of the Intake Team. Inform administrator of report.

The school nurse, as appropriate, will contact Kansas Department of Children and Family Services (DCF) regarding a suspected case of child abuse or neglect, (1-800-922-5330). http://www.dcf.ks.gov/

**Reports are not to be discussed with anyone other than the school administrator.*

Communicable Disease (Board Policy JGCC)

Control of Communicable Disease
The school nurse will observe procedures as given in the communicable disease handbook prepared by the Kansas State Department of Health and Environment. When in doubt about participation, or re- entry to school, the nurse should communicate directly with the student's parents and/or physician. The nurse will follow-up on students with infectious conditions.

Universal precautions should be observed at all times. Gloves should be worn at all times when in contact with body fluids. All body fluids spills will be disinfected with a solution of bleach diluted to a 1:100 solution. Wastebaskets in the nurse's office will be lined with plastic protectors and contaminated articles disposed of properly. All sharp waste products must be placed in the provided sharp waste containers. In the event of latex allergies alternative gloves will be provided.

Report of Communicable Diseases
We have been asked to cooperate with the State Epidemiologist in reporting childhood diseases in order that precautions of epidemics can be made. The school nurse will be notified by the attendance secretary of contagious diseases, as soon as the diseases are reported to the school. Specified communicable diseases should be reported to the Wyandotte County Health Department on Kansas Report of Notifiable Diseases Card.

Completing a Cumulative School Health Record

- Review the past health history of student form, the health intake information form (kindergarten) or the student physical history form (other new students). Record all pertinent health history in Infinite Campus.
- Record any active health problems and health examinations in Infinite Campus
- All Vision/Hearing screening results need to be recorded in Infinite Campus.

- Record any health conditions that occur during the year in Infinite Campus.
- Every student's health record should have a computer printout on file.

Confidential Health Concerns List

This information should be shared with teachers and administrators on a need to know basis. Remember confidentially. The list should be kept in the health room. Share this information with the teachers, stressing confidentially.

Check the annual health information for any health problems that may be described in student's health
folder.

A request from a parent not to share confidential information should always be respected. If in your professional opinion, this puts the student at risk, contact the Director of Special Services.

Dismissal of Ill Students

Students may be dismissed by the school nurse, principal, school secretary, or nurse designee. Students must not be sent home until a parent or designated responsible person is contacted at home or work. Attendance will be changed or marked as Medically Excused.

Elementary Schools

The nurse and teacher will share current information on the health status of each student as appropriate, on an ongoing basis as medical needs change. The teacher will assist with making special arrangements within the classroom. The nurse will be able to schedule screening tests and do other health investigations.

Essential Oils

Essential Oils will not be allowed at Turner USD #202 due to the fact that there are no federal regulations on who can sell essential oils, who can manufacture essential oils who will profit From the sale of essential oils. In addition, there are not enough studies to show long or beneficial outcomes for the use of essential oils, and therefore it becomes very difficult for the medical community to accept or recommend these oils for care.

Essential oils in their pure form are dangerous; they need to be diluted before use. If used in the pure form, essential oils can cause severe irritation and/or permanent skin sensation. Many essential oils are considered poisonous to children and should be kept out of their reach just like other medications.
Immunizations

Exclusion from Physical Education

The school nurse may excuse a student from PE for a temporary period of time-until the temporary condition clears or written confirmation can be obtained from the student's physician.

General Health Policies

- Students who become ill or injured at school may be referred by the teacher for help from the school nurse, principal or school secretary.
- Communicable diseases and suspected infectious conditions should be reported to the school secretary, who will inform the school nurse. When students have been exposed to a communicable disease at school, parents will be notified, under discretion of Administration.
- Students that are sent home from school with a fever or have been diagnosed with a communicable disease should stay home for 24 hours and/or have been on antibiotics for 24 hours.
- Screenings by the school nurse are given to all new students, those referred by parents or school personnel, and all students receiving special education services. These include vision screening and hearing screening. Parents are notified of results when deficiencies are found. Appropriate referrals are made. Mandated screenings will be performed as outlined under screenings.
- Students who present learning problems or who are referred to the special services staff for evaluation will also be referred to the school nurse for screening and evaluation.
- All physical forms for Kindergarten and new students up to the age nine will be given to the school nurse. All medical reports are to be given to the school nurse to be recorded and/or filed in the child's health folder/Document in IC.
- Teachers are encouraged to become aware of the student's individual health conditions. Nurse will communicate with teachers, concerning students' health status.

Head Lice

<u>Information for Parents</u>
Occasionally, we see an increase in the number of students with head lice after we have had a break from school. (i.e. fall, winter, spring break and summer).

Turner Public Schools follows the guidance of KDHE, and the Kansas Classroom Handbook of Communicable Diseases. Kansas regulations do not require individuals with head lice or nits to be excluded from school or child care facilities. The Centers for Disease Control and Prevention (CDC), the American Academy of Pediatrics, and the National Association of School Nurses advocate that children should not be excluded from school due to lice or nits.

What happens when a student has lice at school?

- When a teacher notices that a student has live bugs or the student is scratching their head, neck or ears, they can send the student to the school nurse to check the student for lice.
- If the nurse finds live lice on the student, the nurse will contact parents by phone to let them know. The student will go home for treatment.
- We do not perform mass or classroom head lice screenings.
- Head Lice notices are not sent home each time a student is found to have head lice.

Immunizations: (Board Policy JGCB)

All children **entering a Kansas school for the first time** must present a Kansas Certificate of immunization showing they have received proper immunization for polio, diphtheria, whooping cough, tetanus, rubella (measles) and mumps. Immunizations and/or Health Assessments (physicals) may be obtained through child's family physician or from Wyandotte County Health Department. Students who have not received adequate immunizations according to Kansas Law will be prohibited from attending school.

Students enrolling from **out of the country** should not be allowed to enroll until they present a copy of their immunizations.

Students **transferring to the school district from another school district in Kansas** may be allowed to enroll and attend classes; however, record of evidence of immunizations must be received within 90 calendar days of the student's enrollment date. Students who have not received adequate immunizations within 90 calendar days will be prohibited from attending school.

Parents or guardians of **existing students** who do not meet these immunization requirements will be notified at the time of enrollment. Students who have not received adequate immunizations within 90 calendar days will be prohibited from attending school.

The school nurse is responsible for sending out a total of three request forms (at time of enrollment, 6 weeks, 10 weeks) for notification.

All students not completely immunized within 90 calendar days after admission to school and who have not previously claimed religious and medical exemption will be excluded from school until such time that immunizations have been completed or evidence of a medically approved exemption or postponement is provided to the school. If a parent provides proof of an appointment to the nurse, the student can attend until the given appointment date.

Parents or guardians of students who are excluded from school will be given written notice informing them of the reason for exclusion, the conditions under which the student may return to school and the opportunity for a hearing on the matter upon request of the parent or

guardian if such a request is made in writing within ten (10) calendar days.

Parents or guardians may claim Religious Exemption. Religious Exemption forms need to be renewed each school calendar year. Inform parents of guidelines if there is a student outbreak. http://www.kdheks.gov/immunize/schoolInfo.htm.

Medical Exemption form only needs to be completed one time.

Injury Report (Board Policy JGFG)

Student

Reports will be made on each accident that occurs at school or school functions. Injury reports are to be completed thoroughly and specifically, initiated by building administrator, and kept in the document tab in Infinite Campus. This information is stored for five years. A copy of the report is sent to the Director of Business Services, at the Board of Education as soon as possible. School staff is oriented and encouraged to cooperate with the injury report process by notifying the school nurse immediately.

Guidelines for Injury Reporting

An injury report is to be completed for the following:

- All head injuries. A parent or guardian is to be notified in all cases of head injury
- Sprains (if swollen, painful and limited mobility)
- All teeth injuries
- Lacerations
- If a student has to go to the doctor or hospital
- Broken bones

If there is any doubt about an injury, call parent and make a report. Send a copy of report to District Benefits Coordinator. Insurance paperwork needs to be offered to parents if a report is made.

Employee

When an employee is injured while on duty, three forms must be completed after the first aid is administered. The employee completes the "Report by Injured Employee", the supervisor completes the "Supervisor's Incident Report", and the nurse completes the "Employee's Report of Accident", from the previous reports. The original is sent to the Director of Business Services, as soon as possible. The Employee's Report of Accident does not need to be completed prior to being sent to the Director of Business Services, but lines 1 through 16 should be completed as thoroughly as possible.

If an employee needs further care or assessment, he or she should be sent to the Occupational Health Services, (refer to your Corporate Health Care Form) for further care. Call the Occupational Health Services and inform them and employee is being referred to them. As

possible the employee (or family member) will transport to KU Med. If employee is unable to transport or be transported by family member to KU Med contact either:

- Assistant Superintendent of Human Resources
- Director of Business Services
- Director of Special Services, to determine appropriate means of transportation

In the case of a life-threatening incident, call 911 and do the paperwork later.

Chemical Testing

The board, through its designated workers compensation coordinator, may require employees who claim or are involved in an accident in the course of employment to submit to a post-injury chemical test. This includes instances where the district administration or workers compensation coordinator has actual knowledge of an accident whether the employee has or has not requested medical treatment. Testing will be required if any injury occurs while operating manual or motorized/mechanized equipment. If an employee refuses to submit to an employer requested post-injury chemical test, the employee forfeits all related workers compensation benefits as provided is K.S.A. 44-501(b)(1)(E). Chemical test collection, labeling, and performance shall meet the requirements found is K.S.A. 44-501(b)(3).

Maintenance of Health Records

- Student health records will be completed as thoroughly as possible with the information provided. All information in the health record is confidential and not public record. Health records may be opened at the discretion of the building principal. Health information should be shared discreetly with district personnel who are trustworthy and have a professional interest in the specific student's education.
- When a student transfers to another school, a copy of the health record will be sent if the proper verification is obtained. Immunization data will be given upon request over the telephone.
- Use of available software for maintaining health records is strongly recommended and likely will lead to improved accuracy of health records.
- Doctor notes, immunizations, physicals or any pertinent student medical information will be scanned and uploaded into IC documents tab.

Medication (Board Policy JDDAA), (Board Policy JGFGB), (Board Policy JGFGBA) , (Board Policy JGFGBB)

It is desirable for medication to be administered in the home. However, it is recognized that some students are able to attend school regularly because of the effective use of medication in the treatment of chronic disabilities or illness. It is also recognized that in many short term illnesses, medication may need to be continued after a student returns to school. It is the schools' intent to cooperate with the parent and physician in seeing that the student receives the correct medication and dosage at the proper time.

The initial dose of any medication is to be administered by the parent or guardian and observed at home for at least two (2) hours. In the case of a suspected infectious condition students must have received medication for 24 hours prior to returning to school.

The nurse is responsible for follow-up to see that an appropriate authorization slip is on file and that appropriate procedures are being followed in dispensing of medication.

Medication sheets will be kept in Medication Administration Records (MARS). They will be accessible to nursing staff, but away from students and unauthorized individuals. The sheets must be thoroughly completed.

- Prescription medicine must be in the original prescription container with physician, pharmacy, student's name, medication, dose and time clearly labeled. Over-the-counter medications must be in the original container and will be administered per label directions. A physician's signature is required for prescription medications given on a regular basis, stored in individual containers labeled with name and photo of child and medication dosage.
- Written verification from parent or guardian permitting medication administration must accompany the original prescription container, including over-the-counter medications.
- Medication Administration Records (MAR) will be scanned and uploaded in documents under health in IC.
- Asthma Action Plan from parent/Physician is Required for students with current diagnosis for asthma.
- Diabetes School Orders or Action Plan is required for students with current diagnosis for diabetes.
- Seizure Action Plan is required for students with current diagnosis for seizures.
- Food Allergy Action Plan is required for students with current diagnosis of Food Allergies.
- Disposal of medication - https://www.ojp.gov/pdffiles1/ondcp/prescrip_disposal.pdf
- If a student is required to have emergency medication, emergency medication must be in the attending building at all times. If the emergency medication is not available then the student will be required to go home.

Naloxone – Guidelines for Administration (Board Policy JGFGA)

Naloxone 4mg/O.lmlFDA-approved nasal spray device, 2 doses per unit.
Administer a single spray intranasally into one nostril.
Call 911.
May repeat every 2-3 minutes as needed.

Signs/Symptoms of Opioid Related Overdose:

- A history of current opioid or heroin use or fentanyl patches on skin or needle in the

body

- Unresponsive or unconscious individuals
- Not breathing or slow/shallow respirations
- Snoring, gurgling, or choking sounds due to partial upper airway obstruction
- Blue lips and or nail beds
- Heart rate slows or stops
- Pinpoint pupils
- Clammy skin

Individuals in cardiac arrest from all causes share many symptoms with someone with an opioid overdose (unresponsiveness, not breathing, snoring/gurgling sounds, and blue skin/nail beds). If no pulse, these individuals are in cardiac arrest and require CPR.

Directions for Use:

1. Call 911 as soon as possible for a person suspected of an opioid overdose with respiratory depression or unresponsiveness, and initiate rescue breathing. If in doubt about an overdose, administering naloxone will not harm the victim.
2. Peel back the package to remove the device.
3. Place the victim on their back and tilt their head slightly back. Place the tip of the nozzle in either nostril until your fingers touch the bottom of the patient's nose.
4. Press the plunger firmly to release the dose into one nostril of the patient's nose.
5. If there is no response after 2-3 minutes or if the victim relapses back into respiratory depression or unresponsiveness before emergency assistance arrives, repeat in the other nostril.
6. Continue rescue breathing and monitor respiration and responsiveness of the naloxone recipient until emergency help arrives. Place victim in recovery position.
7. Upon arrival of emergency assistance, report to first responder that naloxone has been administered.
8. Notify the physician medical director of opioid antagonist administration as soon as possible.

Any individual who, in good faith and with reasonable care, prescribes, dispenses, or administers an emergency opioid antagonist pursuant to KAR 68-7-23 is not subject to civil liability, criminal prosecution, or any disciplinary action by a professional licensure entity.

Training for Naloxone in the School Setting

Emergency opioid antagonists provide life-saving treatment to individuals experiencing intentional or accidental overdose by blocking or reversing the effects of opioid-based drugs, including extreme drowsiness, slowed breathing, or loss of consciousness. Beginning July 1, 2017, pharmacists were able to dispense emergency opioid antagonists to patients, bystanders, first responder agencies, and school nurses without a prescription in accordance with the Statewide Protocol. KAR 68-7-23 allows for a first responder, scientist or technician operating under a first responder agency, or a school nurse to possess, store, and administer emergency

opioid antagonists as clinically indicated, provided they receive adequate training. In addition, any individual who, in good faith and with reasonable care, prescribes, dispenses, or administers and emergency opioid antagonist pursuant to KAR 68-7-23 is not subject to civil liability, criminal prosecution, or any disciplinary action by a professional licensure entity.

Description of Clinical Pharmacology of Naloxone

Naloxone hydrochloride (naloxone) prevents or reverses the effects of opioids including respiratory depression, sedation, and hypotension. Naloxone is essentially a pure antagonist, it does not possess the agonistic or morphine-like properties characteristic of other opioid antagonists and exhibits essentially no pharmacologic activity.

Naloxone has not been shown to produce tolerance or cause physical or psychological dependence. In the presence of physical dependence on opioids, naloxone will produce withdrawal symptoms. However, in the presence of opioid dependence, opioid withdrawal symptoms may appear within minutes of naloxone administration and subside in about 2 hours.

Indications for Use of Naloxone

Naloxone is indicated for the complete or partial reversal of opioid depression, including respiratory depression, induced by natural and synthetic opioids.

Contraindications

Known hypersensitivity to naloxone or any of the ingredients contained in the package insert for naloxone.

Precautions

- Use in Pregnancy- Teratogenic Effects: pregnancy category C, no adequate or well controlled studies in pregnant women. Adverse events were not observed in animal reproductive studies. In general, medications used as antidotes should take into consideration the health and prognosis of the mother; antidotes should be administered to pregnant women if there is a clear indication for use and should not be withheld because of fears of teratogenicity.
- Use in Nursing Mothers- Caution should be exercised when administering to nursing women due to transmission in human milk. Risks and benefits must be evaluated.
- Drug Dependence- Those who may be chronically taking opioids are more likely to experience adverse reactions from naloxone. Additionally, after administration, they may awaken disoriented. Being disoriented can sometimes lead to highly combative behavior, including physical violence, especially if naloxone is given by someone unfamiliar.
- Respiration Depression Due to Other Drugs- Naloxone is not effective against respiratory depression due to non-opioid drugs. Initiate rescue breathing or CPR as indicated and contact 911.
- Pain Crisis -In patients taking an opioid medication for a painful illness such as cancer, administration of naloxone can cause a pain crisis, which is an intense increase in the experience of pain as the naloxone neutralizes the pain relieving effect of the opioid

medication. Comfort the patient as much as possible and contact 911 as the patient may need advanced medical treatment to ease the pain crisis.

Adverse Reactions

Related to reversing dependency and precipitating withdrawal (fever, hypertension, tachycardia, seizures, agitation, restlessness, diarrhea, nausea/vomiting, myalgia, diaphoresis, abdominal cramping, nervousness, yawning, sweating, shaking, shivering, hot flashes, and sneezing.

- Symptoms may appear within minutes of naloxone administration and subside in approximately two hours.
- Severity and duration of withdrawal syndrome is related to the dose of naloxone and degree of opioid dependence.
- Reactions may subside within minutes of naloxone administration, but may reappear within approximately 90 minutes. It is imperative that the person experiencing and opioid -related overdose receive medical care following naloxone administration.
- Adverse effects beyond opioid withdrawal are rare.

Risk Factors for Opioid Overdose

- Those taking opioid prescription, particularly in higher doses and in combination with other sedating substance
- Those with household members in possession of opioids
- Those who use opioids and also suffer from depression, mental illness, child abuse, maltreatment, and inadequate supervision
- Those who inject opioids
- Those living in poverty and/or violence in the community

Protective Factors for Opioid Overdose

- Relationships, parental involvement
- Positive self-image, self-esteem, self-control, social competence
- Availability of community resources and after school activities
- Laws and policies relating to opioid prescribing practices
- Laws preventing the availability of alcohol

Strategies to Prevent Opioid Overdose

- Prescription drug monitoring programs, data base tracking of controlled substances
- Education of healthcare providers about safe opioid prescribing practices and fostering conversations with patients and families about risks and benefits of pain treatment options
- Formulary management strategies in insurance programs (prior authorization, quantity limits, drug utilization review)
- Patient education for safe storage and disposal of prescription opioids
- Patient and community education about risks of prescription opioids, cost of opioid overdose

Proper Storage, Disposal, and Expiration

- Store naloxone nasal spray at room temperature between 59 degrees Fahrenheit to 77 degrees Fahrenheit. Naloxone nasal spray may be stored for short periods between 39 degrees. Fahrenheit to 104 degrees Fahrenheit.
- Do not freeze naloxone nasal spray.
- Keep naloxone nasal spray in its box until ready to use. Protect from light.
- Replace naloxone nasal spray before the expiration date on the box.
- Keep naloxone nasal spray and all medicines out of the reach of children.

Nursing Care Plan

A nursing care plan should be written for each student requiring "specialized caretaking" as defined in Kansas Nursing Regulation 60-15-101. Specialized caretaking means catheterization, ostomy care, preparation of food and tube feedings, care of damaged skin integrity and performing other procedures requiring nursing judgment. If a student is identified needing special education the health care plan becomes part of the student's IEP.

Screenings (Board Policy JGCD)

Vision (KS State Policy 72-6242)

Provision of basic vision screening eye examination encouraged for conditions; Kansas children's vision health and school readiness commission.

(a) Basic vision screening shall be provided without charge in accordance with the following:

(1) Annually, for every child participating in IDEA part B programs;

(2) at least once each school year for students enrolled in kindergarten and each of the grades one through three, five, seven and 10 in a school district or an accredited nonpublic school; and

(3) within the first year of admission for any student who enrolls in a school district or an accredited nonpublic school.

(b) (1) Every student enrolled in a school district shall be provided basic vision screening by the board of education of the school district in which the student is enrolled.

(2) Every student enrolled in an accredited nonpublic school shall be provided basic vision screening by either:

(A) The accredited nonpublic school in which the student is enrolled; or

(B) upon request by the student's parent or guardian, by the board of education of the school district in which the student resides.

(c) Basic vision screenings shall be performed by a vision screener designated by the board of education or by an accredited nonpublic school. Vision screeners shall be required to follow the most recent state vision screening guidelines for performing vision screening. The results of the screening and, if necessary, the referral for an examination by an ophthalmologist or optometrist shall be reported to the parents or guardians of the student. The referral for an

examination by an ophthalmologist or optometrist shall not show preference in favor of any such ophthalmologist or optometrist.

(d) Each student needing assistance in achieving mastery of basic reading, writing and mathematics skills shall be encouraged to obtain an eye examination by an optometrist or ophthalmologist to determine if the student suffers from conditions that impair the ability to read. Expense for such examination, if not reimbursed through Medicaid, private insurance or any other governmental or private program, shall be the responsibility of the student's parent or guardian.

The schedule followed by Turner USD 202 is:

- All new students
- All teacher, parent, and student referrals
- All special education students and students with handicapping conditions
- All students in PK, K, 1st,2nd, 3rd, 5th, 7th and 10th grades

Specific procedures should be reviewed in the Kansas Vision Screening Requirements and Guidelines published by the Kansas State Department of Health and Environment.
https://drive.google.com/file/d/1IbieZlN8AEDS1wuqOyGiQHWs8vc8sno0/view?pli=1

Hearing Screening (KS State Policy 72-6229)

Free tests required; when and by whom tests performed; reports to parents.

(a) Every pupil enrolled in a school district or an accredited nonpublic school shall be provided basic hearing screening without charge during the first year of admission and not less than once every three years thereafter.

(b) Every pupil enrolled in a school district shall be provided basic hearing screening by the board of education of the school district in which the pupil resides and is enrolled.

(c) Every pupil in an accredited nonpublic school shall be provided basic hearing screening either (1) by the board of education of the accredited nonpublic school in which the pupil is enrolled, or (2) upon request therefor by the pupil's parent or guardian, by the board of education of the school district in which the pupil resides. No board of education of a school district shall be required to provide basic hearing screening outside the school district. If the accredited nonpublic school in which the pupil is enrolled is located within the school district, basic hearing screening shall be provided in the nonpublic school. If the accredited nonpublic school in which the pupil is enrolled is located outside the school district, basic hearing screening shall be provided in a school of the school district.

(d) All tests shall be performed by a person competent in the use of a calibrated audiometer and who has been designated by the board of education which provides the basic hearing screening. The results of the test and, if necessary, the desirability of examinations by a qualified physician shall be reported to the parents or guardians of such pupils

The schedule followed by Turner USD 202 is:

- All new students
- All teacher, parent, and student referrals
- All special education students and students with handicapping conditions
- All students in PK, K, 3rd, 6th, 9th and 12th grades

Specific procedures should be reviewed in the Guidelines for Hearing Screenings published by the Kansas State Department of Health and Environment.
https://www.ksde.org/Portals/0/SES/Senses/HearingScreeningGuidelines.pdf

Dental (State Policy 72-6252)

Said boards of education and district boards of each school shall provide a place of inspection and designate some competent, licensed dentist or dentists to make such inspection, and such boards of education and district boards may fix a compensation for such services, which sum may be paid out of the school fund of each school for the services rendered therein, and said boards of education for their respective cities and the county superintendent of public instruction for school districts are hereby authorized to make all necessary rules and regulations for the proper conduct of such inspection and carrying into effect all of the provisions of the preceding section, and furnish all necessary forms and blanks for the reports of such inspection.

- Yearly visit. Big Smiles Dentistry. Contact person: Mary Ellen Whittington. mwhittington@mobiledentists.com 1-888-833-8441 Ext 60111

Secondary Schools

The nurse will consult with the building principal and decide on the manner of delivery of health information.

Teacher / Nurse Communication

Special health needs of children are interpreted to the school personnel by the nurse and plans are made to meet the needs of the student. Staff should always be aware of the confidential nature of health information and restrict sharing information.

Time and Effort Logs

Time and Effort Logs are required for the yearly KSDE special education audit. They must be completed electronically, and sent to the Special Services office on a monthly basis.

Resources

Turner School Board Policy Manual (especially section J related to students)

- Board Policies and Regulations

The school nurse is expected to be familiar with this material and conduct the nursing program in compliance with Board policy.

Kansas Department of Health and Environment

- KDHE Website

Kansas Dept. of Health and Environment Bureau for Children, Youth and Families
1000 SW Jackson, Suite 220
Topeka, KS. 66612
Fax - 785-296-4166

Christine Tuck, Child Health/School Health Consultant
785-296-7433
ctuck@kdhe.state.ks.us

Sue Bowden, Director, Kansas Immunization Program
785-296-0687
sbowden@kdhe.state.ks.us

KDHE On-line news for school nurses
www.kdhe.state.ks.us/c-f/zips/index.html

Children and Families Section, School Health Documents (view under KDHE website)

- Comprehensive School Health Services Center Initiative
- School Nursing and School Health Services – A Planning and Resource Guide
- Guidelines for Medication Administration in Kansas Schools
- Kansas Nurse Practice Act
- Guidelines for Serving Students with Special Health Care Needs
- Guidelines for Serving Students with Special Health Care Needs, Part II
- Animals in Kansas Schools: Guidelines for Visiting and Resident Pets
- Dealing with Head Lice: A Practical Approach for Schools, Parents and Communities
- Emergency Procedures" Guidelines for the Nurse in the School Setting
- Kansas Classroom Handbook on Communicable Diseases
- Class Act Physical Activity Guide (Curriculum for school teachers K-5)

- KDHE Health Education Fact Sheet

Kansas State Law (Statues)

Access through Kansas Department of Health and Environment Website

- www.kdhe.state.ks.us

Unified Government of Wyandotte County

- www.wycokck.org/departments/public

Juvenile Justice Administration
701 North 7th Street, Suite 715
Kansas City, Kansas 66101

American Lung Association of Kansas

- www.ks.lung.org

4300 SW Drury Lane
Topeka, Kansas 66604
785-272-9290
Fax: 785-272-9297
800-586-4872

Kansas State Department of Education

- www.ksde.org

120 S.E. 10th Avenue
Topeka, KS. 66612-1182

Health and Physical Education, Human Sexuality and HIV/AIDS/STD
Dr. Darrel Lang, Ed.D.
Education Program Consultant
785-296-6716
Fax: 785-296-5867

Poison Control
1-800-222-1222

Appendix

Allergy Action Plan

Name: _____ **Date of Birth:** _____

Allergy to: _____

Weight: _____lbs. **Asthma:** ☐ Yes (higher risk for a severe reaction) ☐ No

Place Student's Picture Here

Extremely reactive to the following foods: _____

THEREFORE:

☐ If checked, give epinephrine immediately for ANY symptoms if the allergen was *likely* eaten.

☐ If checked, give epinephrine immediately if the allergen was *definitely* eaten, even if no symptoms are noted.

Any SEVERE SYMPTOMS after suspected or known ingestion:

One or more of the following:

LUNG:	Short of breath, wheeze, repetitive cough
HEART:	Pale, blue, faint, weak pulse, dizzy, confused
THROAT:	Tight, hoarse, trouble breathing/swallowing
MOUTH:	Obstructive swelling (tongue and/or lips)
SKIN:	Many hives over body

Or **combination** of symptoms from different body areas:

SKIN:	Hives, itchy rashes, swelling (e.g., eyes, lips)
GUT:	Vomiting, crampy pain

1. **INJECT EPINEPHRINE IMMEDIATELY**
2. Call 911
3. Begin monitoring (see box below)
4. Give additional medications:*
   -Antihistamine
   -Inhaler (bronchodilator) if asthma

*Antihistamines & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE.

MILD SYMPTOMS ONLY:

MOUTH:	Itchy mouth
SKIN:	A few hives around mouth/face, mild itch
GUT:	Mild nausea/discomfort

1. **GIVE ANTIHISTAMINE**
2. Stay with student; alert healthcare professionals and parent
3. If symptoms progress (see above), USE EPINEPHRINE
4. Begin monitoring (see box below

Medications/Doses

Epinephrine (brand and dose): _____

Antihistamine (brand and dose): _____

Other (e.g., inhaler-bronchodilator if asthmatic): _____

Monitoring

Stay with student; alert healthcare professionals and parent. Tell rescue squad epinephrine was given; request an ambulance with epinephrine. Note time when epinephrine was administered. A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping student lying on back with legs raised. Treat student even if parents cannot be reached. See back/attached for auto-injection technique.

_____ _____ _____ _____

Parent/Guardian Signature **Date** **Physician/Healthcare Provider Signature** **Date**

TURNER SCHOOL UNIFIED SCHOOL DISTRICT #202

Food Allergy Evaluation Form

Student Name: _____ Date of Birth: _____

School: _____ Grade: _____ Teacher: _____

Does your child have a food allergy? ☐ Yes ☐ No

If yes, list food child is allergic to _____

_____

What happens when your child has this food? _____

_____

Is this allergy severe or life threatening to where an Epi Pen is needed? ☐ Yes ☐ No

Will your child need meal modifications? ☐ Yes ☐ No

**If yes, you will need to provide a doctor's order stating modifications and what your child needs as a replacement.*

Any other specifications? _____

_____

_____

_____ _____

Parent Signature Date

TURNER SCHOOL UNIFIED SCHOOL DISTRICT #202

HEALTH INFORMATION DOCUMENTATION
2024-2025
TO BE COMPLETED BY PARENT or GUARDIAN AND RETURNED TO NURSE ASAP

Student's Name _____ DOB _____ Grade _____ School _____

Does the student currently or have had in the past, any of the following conditions? (Attach any pertinent information)

CONDITIONS & ILLNESSES	YES	NO	CONDITIONS & ILLNESSES	YES	NO
Food Allergies			Hearing Loss / Correction		
Environmental Allergies			Heart Condition / Murmur		
Bee / Insect Sting Allergy or Reaction			Hepatitis		
ADHD / ADD			Hernia		
Anemia (include Sickle Cell)			Lead		
Arthritis			Lung Disease / Tuberculosis		
Asthma (give details below)			Measles		
Back / Neck Injury			Medication Reaction / Allergy (list below)		
Bladder / Kidney Disease			Mononucleosis		
Bleeding / Clotting Disorder			Orthopedic / Bone		
Cancer / Leukemia			Psychological / Psychiatric		
Chickenpox			Surgery		
Convulsion/ Seizures			Speech		
Diabetes			Vision Loss		
Head Injury / Concussion			Other (explain below)		
Headaches					

Please give details and doctor's documentation to answers marked YES. _____

_____

Is the student currently undergoing any kind of **medical care** or **treatment**? YES ☐ NO ☐

Explain: _____

_____

Is the student taking any medication on a regular basis (prescription or non-prescription)? YES ☐ NO ☐

List student's current medications (dose, time & reason). _____

_____

**Contact the school nurse to make arrangements for any meds to be given at school. A signed consent by the physician and parent for prescription medication, and a signed consent by parent for over the counter medication must be obtained.*

Describe any modifications or restrictions that are necessary to accommodate your child's health, safety or welfare. _____

_____

Parent / Guardian Signature _____ Date _____

TURNER SCHOOL UNIFIED SCHOOL DISTRICT #202

HEALTH INFORMATION DOCUMENTATION
2024-2025
DEBE COMPLETARLO EL PADRE O EL TUTOR Y REGRESAR A LA ENFERMERA DE LA ESCUELA LO MAS PRONTO

Nombre del Estudiante_____ Fecha de Nacimiento _____ Grado ____ Escuela _____

Tiene su niño actualmente o en el pasado, una de las siguientes condiciónes Medicas? (Adjunte cualquier información pertinente)

CONDICIONES Y ENFERMEDADES	SI	NO	CONDICIONES Y ENFERMEDADES	SI	NO
Alergias /Estacional, alimento y			Pérdida de oído / Corrección		
Abeja /Picadura de Insectos Alergia o Reacción			Condicion del Corazón/ Murmullos		
ADHD / ADD			Hepatitis		
Anemia (incluya la célula falciform)			Hernia		
Artritis			Plomo		
Asma (detalles de la elasticidad abajo)			Enfermedades del Pulmón / Tuberculosis		
Espalda /Lesión del Cuello			Sarampión		
Enfermedad de la Vejiga/del Riñón			Reacción a la Medicina / Alergia (lista		
Sangrado / Desorden de coagulación			Mononucleosis		
Cancer / Leucemia			Ortopédico / Hueso		
Varicela			Psicologico/Psquiátrico (ansiedad,		
Convulsión/ Ataques			Cirugía		
Diabetes			Habla		
Lesión en la Cabeza / Conmoción			Perdida de Vista / Corrección		
Dolores de Cabeza			Otro (explique abajo)		

Dé por favor los detalles y las fechas a las respuestas SI. _____

_____

Está el estudiante actualmente bajo cualquier asistencia médica o en tratamiento? SI ☐ NO ☐

Explain: _____

_____

El estudiante está tomando medicamentos regularmente (con reseta o sin reseta)? SI ☐ NO ☐

Lista de los estudiantes y los medicamentos actuales (dosis, tiempo y razón). _____

_____

**Contactar a la enfermera de la escuela para hacer arreglos de los medicamentos que deben ser dados en la escuela. Un consentimiento firmado por el médico y el padre para el medicación con prescripción, y un consentimiento firmado por el padre sobre la medicación sin reseta deben ser obtenidos.*

Describa cualesquiera modificaciones o restricción que sean necesarias para acomodar la salud, la seguridad o el bienestar de su niño.

_____

Parent / Guardian Signature _____ Date _____

TURNER SCHOOL UNIFIED SCHOOL DISTRICT #202

ASTHMA TREATMENT PLAN

- ☐ Intermittent
- ☐ Mild Persistent
- ☐ Moderate Persistent
- ☐ Severe Persistent

Student's Name _____

Date of Birth _____/____/_____

Grade _____

THE ABOVE STUDENT IS DIAGNOSED WITH ASTHMA. THIS FORM WILL ASSIST IN THE MANAGEMENT OF HIS/HER ASTHMA. PLEASE PLACE THIS FORM IN THE STUDENT'S MEDICAL FILE.

Parent/Guardian Name: _____ Address: _____ City, State, Zip: _____ Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____	**Triggers:** ☐Smoke ☐Weather ☐Air Pollution ☐Colds ☐Dust ☐Exercise ☐Animals ☐Food ☐Other _____ _____
Student's Primary Care Provider: _____	Phone: (____) _____

Daily Medication Plan

This is the student's daily medicine plan:	**Medicine / Dose**	**When to Give it**
• The student has no asthma symptoms. • The student can do usual activitie • The student can sleep without symptoms.	☐ Albuterol/Xopenex inhaler 2 sprays OR ☐ Albuterol/Xopenex solution 1 dosage ☐ _____ ☐ Albuterol/Xopenex inhaler 2 sprays OR nebulizer treatment 15-20 minutes before exercise, only if needed	Every 4-6 hours as needed for wheezing/cough

Asthma Emergency Plan

Do this **first** when asthma symptoms occur:	Have the student take albuterol inhaler 2-6 sprays OR one nebulizer treatment every 20 minutes up to 2 times. This is a **test dose** to see if the student's asthma improves with emergency inhaler.
What to Do Next:	**When to Do It:**
☐ Have the student return to the classroom. ☐ Notify parents of student's need for quick relief medicine.	**Good Response to Test Dose of Albuterol** • The student's symptoms improve after 1-2 treatments. • The student no longer has symptoms (wheezing, coughing, shortness of breath, chest tightness). • Student may continue Albuterol/Xopenex every 4 hours for 24-48 hours.
☐ Contact the parent or guardian. ☐ Contact the PCP for step-up medicine. ☐ _____	**Incomplete Response to Test Dose of Albuterol** • The student is experiencing mild to moderate symptoms (wheezing, coughing, shortness of breath, chest tightness) after taking up to 3 treatments. • The student cannot do normal school activities.
☐ Call the PCP_____ ☐ Seek emergency medical care (in most locations, call 911) ☐ _____ NOTE: Wheezing may be absent because air cannot move out of the airways.	**Poor Response to Test Dose of Albuterol** • The student does not feel better 20-30 minutes after taking the albuterol. • The student has severe symptoms (coughing; extreme shortness of breath; skin retracts between the ribs **or** at the neck). • The student has trouble walking or talking. • The student's lips or fingernails are blue. • The student is struggling to breathe.

_____ _____

Parent/Guardian Signature Date Physician Signature Date

Delegation of Specific Nursing Tasks in the School Setting for Kansas (see K.A.R. 60-15-101 through 104)

The following table is to be used to determine to whom **Specialized Caretaking** tasks or procedures may be delegated. Only the Registered Professional Nurse (RN) responsible for the student's nursing care may determine which nursing tasks may be delegated to an Unlicensed Assistive Person (UAP). The RN or the Licensed Practical Nurse (LPN) shall supervise all nursing tasks delegated in accordance with the criteria listed in KAR 60-15-101 through104. Depending on parental permission and the age and maturity level of the child, many tasks may be performed by the child with oversight by the RN or LPN. **Basic Caretaking** tasks **(including bathing, dressing, grooming, routine dental, hair and skin care, preparation of food for an oral feeding, exercise – [excluding OT and PT], toileting and diapering, hand washing, transferring, and ambulation)** may be performed by a UAP without delegation.

After assessment and consideration of the principles of delegation, the decision to delegate nursing care must be based on the following: 1) The nursing task involves no nursing judgment. Judgment involves substantial specialized knowledge derived from biological, behavioral and physical sciences applied to decisions, 2) The UAP skills and competency levels, and 3) The supervision criteria in KSA 65-1165 are evaluated and met.

A = Allowed within Scope of Practice S = Within Scope of Practice with Supervision D = Delegated task with RN or LPN supervision X = Cannot perform					**Provider** = Person w/legal authority to prescribe (e.g. MD, DO, DDS, and ARNP or PA with protocol authority) **RN and LPN** = Licensed health professionals regulated by Kansas Nurse Practice Act **UAP** = All other school employees assisting with health services not licensed as a RN or LPN	
Specialized Caretaking	**Provider Order Required**	**RN**	**LPN**	**UAP**	**Self administration**	**RN Scope of Practice**: The delivery of health care services which require assessment, nursing diagnosis, planning, intervention & evaluation. **LPN Scope of Practice**: The delivery of health care services which are performed under the direction of the RN, licensed physician, or licensed dentist, including observation, intervention, and evaluation. **Self administration**: As agreed between RN or LPN and parent/provider.
Prescription Medications: Oral, topical, nasal, inhalers, nebulizer and rectal	Yes	A	S	D*	A	*If does not require dosage calculation and nursing care plan denotes route.
Prescription Medications: Intramuscular	Yes	A	S#	X#	A	# No, unless an emergency medication as specified per an Emergency Action Plan (EAP). RN/LPN supervision.
Prescription Medications: Through tubes inserted into the body	Yes	A	S	X+	A	+Except a feeding tube inserted directly into the abdomen
Prescription Medications: Intermittent Positive Pressure Breathing Machines	Yes	A	S	X	A	
Prescription Medications: Intravenous	Yes	A	S**	X	A	**According to LPN IV therapy law
Over the Counter Medications	*	A	A	A	A	*Individual district policy may vary in requirements and limitations.
Diabetes Care: Blood glucose monitoring and/or carbohydrate counting and/or subcutaneous insulin administration	Yes	A	S	D	A	
Catheterization	Yes	A	S	D	A	
Ostomy Care	Yes	A	S	D	A	
NG feeding: preparation and/or administrations	Yes	A	S	X	A	
G-tube feedings: preparation and/or administration	Yes	A	S	D	A	
Reinsertion of percutaneous g-tube	Yes	A	S	D	A	
First feeding after reinsertions of g-tube	Yes	A	S	X	A	
Care of skin with damaged integrity	Yes	A	S	D	A	
Care of skin with potential for damage	No	A	S	D	A	
Tracheostomy: Care of ostomy, trach and/or suctioning	Yes	A	S	D	A	
Tracheostomy: Reinsertion of established	Yes	A	S	X##	A	## No, unless an emergency procedure as specified per an Emergency Action Plan (EAP). RN/Certified LPN supervision.
Mechanical Ventilation: Management of	Yes	A	S	X	A	
Measuring Vital Signs	No	A	S	D	A	
Development of Individualized Health Care Plan & EAP (Emergency Action Plan)	No	A	X	X	X	

Kansas Diabetes Health Care Plan

Physician to Complete **Date of Plan:** _____

Student's Name: _____ Date of Birth: _____

Blood Glucose Monitoring
Target range for blood glucose is 70-150 70-180 other _____

Times to check blood glucose *(circle all that apply)*
Circle specific time of day: 8a 9a 10a 11a before lunch after lunch 1p 2p 3p 4p Other _____
before exercise after exercise when student exhibits symptoms of hypoglycemia or hyperglycemia
Check urine with ketone strip if blood sugar is greater than 280 mg/dL.
Notify Physician if urine ketones are: present moderate amt. large amt do not notify

ORDERS FOR MEDICATION
Oral Diabetes Medications Not Applicable
Type of medication: _____ Dosage_____ Frequency_____

Sub-q Insulin and Dosage: Not Applicable
Type_____ Dosage_____ Frequency_____

Insulin Pen _____ Please circle type: Luxura, Humalog Disposable, Novolog Jr., Novolog Flexp

Sliding Scale Insulin and Dosage: Not Applicable
Type of Insulin

If BS is _____	to	mg/dl give	units of insulin	If BS is	to	mg/dl give	units of insulin
If BS is _____	to	mg/dl give	units of insulin	If BS is	to	mg/dl give	units of insulin

Insulin Pumps Not Applicable Follow pump orders as prescribed by specialist/endocrinologist
Type of pump: _____ Type of Insulin in pump_____
Type of infusion set: _____ Algorithm available? yes no

Insulin to carbohydrate ratio: _____ Sensitivity: _____ Bolus Range: _____

Basal rates: _____ ___to ___ ____ ___to ___
____ ___to ___ ____ ___to ___

Correction for Hypoglycemia
If student is unconscious or having a seizure, presume the student is having low blood glucose and Call 911 immediately; administer glucagon; and notify parents.
____Glucagon ½ mg; 1mg; _____mg; (circle desired dose) sub-q/IM should be given immediately.
____Glucose gel 1 tube inside cheek and massage from outside while waiting or during administration of glucagon.
____Glucagon/glucose gel could be used if student has documented low blood sugar; is vomiting; unable to swallow.
Student should be turned on side and maintained in this "recovery" position until fully awake.

Insulin Correction Dosage for Hyperglycemia
Type of Insulin _____
If BS is ___ to ____mg/dl give ____units of insulin sq If BS is ___ to ____mg/dl give ____units of insulin sq
If BS is ___ to ____mg/dl give ____units of insulin sq If BS is ___ to ____mg/dl give ____units of insulin sq

Other Instructions _____

Physician's Name _____ Phone (_____) _____
Physician's Signature _____ Date _____

TURNER SCHOOL UNIFIED SCHOOL DISTRICT #202

Diabetic Self-Management Form

Name of Student: _____ Grade: _____

The above student has been instructed in the proper management of their diabetes.

We request he/she be permitted to:

- ☐ Perform blood glucose level check
- ☐ Administer insulin through the delivery system the student uses
- ☐ Treat hypoglycemia and hyperglycemia
- ☐ Possess the supplies or equipment necessary to monitor and care for their diabetes
- ☐ Otherwise, attend to the management and care of the student's diabetes in the school or at any other school-related activity.

Notwithstanding the above, the district reserves the right to put reasonable place and manner procedural safeguards in place for the safe and non-disruptive exercise of such rights by students with diabetes.

Employee Immunity:

The board and its employees and agents, who authorize the self-administration of medication and treatment for diabetes in compliance with the provision of this policy, shall not be liable in any action for any injury resulting from the self-administration of medication. The district shall provide written notification to the parent or guardian of a student for whom this policy is applicable that the board and its employees and agents are not liable for any injury resulting from the self-administration of medication. The parent or guardian shall sign such notice and acknowledge that the district incurs no liability for any injury resulting from the self-administration of medication and agrees to indemnify and hold the board and its employees and agents harmless against any claims relating to the self-administration of medication pursuant to this policy.

*See attached School Board Policy JGFGBB: Accommodating Students with Diabetes

Parent/Guardian Signature _____ Date _____

Phone Number (_____) _____

Thank you,

TURNER SCHOOL UNIFIED SCHOOL DISTRICT #202

Request for Diabetic Medical Supplies

Student's Name _____ Date _____

School _____ Grade _____

Nurse _____ Date _____

This is a notification regarding your student's individual doctor's order, which requires updating or ensuring the availability of necessary medical supplies for use during school hours. Please confirm that your student has all required supplies readily available.

If any of the items listed below are checked, it indicates that none are currently available at the school. Insulin and all supplies required to give insulin (If student has an electronic device that delivers insulin, backup supplies need to be available in the event that device malfunctions.

- ☐ Glucagon for emergency use
- ☐ Ketone Strips
- ☐ Machine to monitor glucose levels and all supplies required to do so. (If monitored by CGM device, student should have a backup glucometer and supplies in case of emergency)
- ☐ Updated doctor's orders
- ☐ Other _____

All required supplies must be at school by _____. **Failure to provide supplies will result in student being unable to attend.**

For questions, please contact your child's school nurse at _____.

Sincerely,

School Nurse

TURNER SCHOOL UNIFIED SCHOOL DISTRICT #202

Documentation of Instruction

Instruction and Supervision from the Registered Nurse to Unlicensed Assistive Personnel

School Year _____

Instructions: The school nurse and unlicensed assistive personnel (UAP) must complete this form in full when a nursing task is delegated. Each delegated nursing task must be listed below. This form must be kept on record and maintained in the health office.

Printed name of UAP: _____

The undersigned non-nursing school personnel have been instructed in:

(Identify Nursing Tasks)

The above UAP has satisfactorily demonstrated the ability to carry out the identified nursing task(s). Both the registered nurse and the unlicensed person agree that the task(s) can be safely delegated and carries out by the unlicensed person designated below. Direct supervision / observation of the delegated task must be done at least **twice during the academic year** in a joint evaluation with the UAP in accordance with the requirements of K.A.R. 60-15-103. Periodic supervision beyond the two required supervisions is at the discretion of the registered nurse (RN).

DOCUMENTATION OF SUPERVISION BY THE REGISTERED NURSE (RN) TO NON-NURSING UNLICENSED ASSISTIVE PERSONNEL (UAP)

Date of Supervision	Initials of Both Parties		Comments

_____ _____ _____

Signature of UAP Initials Date

_____ _____ _____

Signature of RN Providing Instruction Initials Date

TURNER SCHOOL UNIFIED SCHOOL DISTRICT #202

Documentation of Nursing Tasks Delegated to Unlicensed School Personnel

School _____

Student _____ Teacher _____ Grade _____

Physician _____ Phone Number _____

Treatment Prescribed (Task) _____

Number of Days to be Given at School _____ Potential Hazards _____

Initial Nursing Assessment _____

Date of Initial Instruction _____ Date Care Began _____

_____

Signature of Delegating Nurse (Name and Title)

_____

Signature of Unlicensed School Personnel (Name and Title)

Log of Nursing Tasks Provided at School by Written Physician Order

Date	Time	Student	Administered by Initials	Comments	Date of RN Supervision

TURNER SCHOOL UNIFIED SCHOOL DISTRICT #202

Documentation of Individuals Trained to Dispense Medications for School Year _____.

Building:

☐ Junction	☐ Midland Trail	☐ Oak Grove	☐ Turner Elementary
☐ Journey	☐ Middle School	☐ High School	☐ Journey

The following individuals have been trained to dispense medications and/or act as the nurse designee in the absence of the school nurse.

Employee	Employee Signature	Date

_____ _____

Signature of Registered Nurse Date

EP PEN Auto njector and EP PEN Jr Auto njector D rect ons

F rst, remove the EP PEN Auto njector from the p ast c carry ng case

Pu off the b ue safety re ease cap

Ho d orange t p near outer th gh (a ways app y to th gh)

Sw ng and f rm y push orange t p aga nst outer th gh Ho d on th gh for approx mate y 10 seconds. Remove the EP PEN Auto njector and massage the area for 10 more seconds

EPIPEN 2-PAK | EPIPEN Jr 2-PAK

(Epinephrine) Auto-Injectors 0.3/0.15mg

DEY and the Dey logo, EpiPen, EpiPen 2-Pak, and EpiPen Jr 2-Pak are registered trademarks of Dey Pharma, L.P.

Twinject® 0.3 mg and Twinject® 0.15 mg Directions

Remove caps labeled "1" and "2."

Place rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.

SECOND DOSE ADMINISTRATION:
If symptoms don't improve after 10 minutes, administer second dose:

Unscrew rounded tip. Pull syringe from barrel by holding blue collar at needle base.

Slide yellow collar off plunger.

Put needle into thigh through skin, push plunger down all the way, and remove.

Adrenaclick™ 0.3 mg and Adrenaclick™ 0.15 mg Directions

Remove GREY caps labeled "1" and "2."

Place RED rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.

A food allergy response kit should contain at least two doses of epinephrine, other medications as noted by the student's physician, and a copy of this Food Allergy Action Plan.

A kit must accompany the student if he/she is off school grounds (i.e., field trip).

Contacts

Call 911 (Rescue Squad): (___) _____ Doctor Name: _____ Phone: (_____) _____

Parent/Guardian: _____ Phone: (_____) _____

Other Emergency Contacts

Name/Relationship: _____ Phone: (_____) _____

Name/Relationship: _____ Phone: (_____) _____

TURNER SCHOOL UNIFIED SCHOOL DISTRICT #202

Epi-Pen Release Form

Name of Student: _____

Grade: _____

Date: _____

The above student has been instructed in the proper use of _____

We request he/she be permitted to carry the Epi-Pen on his/her person as we consider him/her responsible. The student has been instructed in and understands the purpose and appropriate method and frequency in the use of the Epi-Pen.

We, the undersigned, absolve the school or any responsibility in safeguarding the student's Epi-Pen.

_____ _____

Physician's Signature Parent/Guardian Signature

_____ _____

Physician's Contact Number Parent Contact Number

It is strongly advised that each student leave an extra Epi-Pen in the nurse's office in the event of a misplaced epi-pen.

Thank you,

School Nurse.

TURNER SCHOOL UNIFIED SCHOOL DISTRICT #202

Dear Parent of a Fourth Grade Student:

Young adolescents want to know about the changes their bodies are experiencing. Although we want our young students to first ask a parent or other family member questions about growing up, we also believe it is important students know other adults are available to explain about body changes and sexuality in general.

On _____we will begin our annual Life Skills Program dealing with human sexuality issues. This year's program will be planned and presented by your classroom teachers, the school nurse, and the Unified Government Health Department.

The lesson will be presented separately for boys and for girls and will be about one hour in length. The topics covered include personal hygiene, male and female reproductive anatomy and physiology, puberty changes, and AIDS.

If you have questions about the information to be covered, please call your child's school nurse at 913 - _____. Parents are encouraged to view the puberty curriculum online. A Youtube link will be provided upon request.

Sincerely,

School Nurse

Please return to school

☐ No, I would not like my child to attend the growth and development presentation.

Student Name (Print) _____

Parent Signature _____

TURNER SCHOOL UNIFIED SCHOOL DISTRICT #202

Dear Parent of a Fifth Grade Student:

Young adolescents want to know about the changes their bodies are experiencing. Although we want our young students to first ask a parent or other family member questions about growing up, we also believe it is important students know other adults are available to explain about body changes and sexuality in general.

On _____we will begin our annual Life Skills Program dealing with human sexuality issues. This year's program will be planned and presented by your classroom teachers, the school nurse, and the Unified Government Health Department.

The lesson will be presented separately for boys and for girls and will be about one hour in length. The topics covered include personal hygiene, male and female reproductive anatomy and physiology, puberty changes, and AIDS.

If you have questions about the information to be covered, please call your child's school nurse at 913 - _____. Parents are encouraged to view the puberty curriculum online. A Youtube link will be provided upon request.

Sincerely,

School Nurse

Please return to school

☐ No, I would not like my child to attend the growth and development presentation.

Student Name (Print) _____

Parent Signature _____

TURNER SCHOOL UNIFIED SCHOOL DISTRICT #202

Dear Parent of a Sixth Grade Student:

Young adolescents want to know about the changes their bodies are experiencing. Although we want our young students to first ask a parent or other family member questions about growing up, we also believe it is important students know other adults are available to explain about body changes and sexuality in general.

On _____we will begin our annual Life Skills Program dealing with human sexuality issues. This year's program will be planned and presented by your classroom teachers, the school nurse, and the Unified Government Health Department.

The lesson will be presented separately for boys and for girls and will be about one hour in length. The topics covered include personal hygiene, male and female reproductive anatomy and physiology, puberty changes, and AIDS.

If you have questions about the information to be covered, please call your child's school nurse at 913 - _____. Parents are encouraged to view the puberty curriculum online. A Youtube link will be provided upon request.

Sincerely,

School Nurse

Please return to school

☐ No, I would not like my child to attend the growth and development presentation.

Student Name (Print) _____

Parent Signature _____

TURNER SCHOOL UNIFIED SCHOOL DISTRICT #202

Estimados Padres:

Los adolescentes jóvenes quieren saber acerca de los cambios que están experimentando sus cuerpos. Aunque queremos que nuestros jóvenes estudiantes primero hagan preguntas a los padres u otros miembros de la familia sobre el crecimiento, también creemos que es importante que los estudiantes sepan que otros adultos están disponibles para explicar los cambios corporales y la sexualidad en general.

El _____ comenzaremos nuestro Programa anual de Habilidades para la Vida que trata los problemas de la sexualidad humana. El programa de este año será planeado y presentado por sus maestros, la enfermera de la escuela y el Departamento de Salud del Gobierno Unificado.

La lección se presentará por separado para niños y para niñas y durará aproximadamente una hora. Los temas que se cubriran incluyen higiene personal, anatomía y fisiología reproductiva masculina y femenina, cambios en la pubertad y SIDA.

Si tiene alguna pregunta sobre la información a cubrir, llame a la enfermera de la escuela de su hijo al 288 - _____. Se anima a los padres a ver el currículo de pubertad en línea. Un enlace de You Tube se proporcionará a petición.

Sinceramente,

Enfermera de la Escuela

Regrese a la Esacuela

☐ No me gustaría que mi hijo asistiera a la clase de maduración.

Nombre del estudiante (Imprimir) _____

Firma del Padre _____

TURNER SCHOOL UNIFIED SCHOOL DISTRICT #202

Head Injury Notification

Student's Name: _____ Date: _____

This letter is to notify you that your child received an injury to the head and was seen by the school nurse. He/She was experiencing no problems at that time, but they should be watched for any of the following symptoms.

A concussion can affect memory, judgment, reflexes, speech, balance and muscle coordination. People with concussions often report a brief period of amnesia or forgetfulness, where they cannot remember what happened immediately before or after the injury. They may act confused, dazed or describe "seeing stars." Paramedics and athletic trainers who suspect a person has suffered a concussion may ask the injured person if they know their name, what month/year it is and where they are.

Common Symptoms of Concussion

- Confusion
- Headache
- Vision disturbances (double or blurry vision)
- Dizziness or imbalance
- Nausea or vomiting
- Memory loss
- Ringing ears
- Difficulty concentrating
- Sensitivity to light
- Trouble falling asleep

If any of these occur after a blow to the head, a health-care professional should be consulted as soon as possible.

When to Seek Medical Care

Most people will recover quickly and completely following a concussion. Some people can have symptoms that last for several weeks before gradually getting better. Seek immediate medical attention if:

- Headache is worse or does not go away
- Slurred speech, weakness, numbness or decreased coordination
- Significant nausea or repeated vomiting
- Seizures
- Loss of consciousness
- Inability to wake up
- Symptoms have worsened at any time
- Symptoms have not gone away after 10-14 days
- History of multiple concussions

School Nurse: _____ Phone: (913) _____

TURNER SCHOOL UNIFIED SCHOOL DISTRICT #202

Health Notification

This memo is to inform you that your child may have been exposed to the following:

Date of exposure _____

☐ Chicken Pox	☐ Fifth Disease	☐ German Measles
☐ Hepatitis	☐ Influenza	☐ Mononucleosis
☐ H1N1 Virus	☐ MRSA	☐ Mumps
☐ Pink Eye	☐ Ringworm	☐ Scabies
☐ Scarlet Fever	☐ Other _____	

For more information on any of these diseases, please visit the Wyandotte County Public Health Department website at http://www.wycokck.org/dept.aspx?id=488&menu_id=958 or contact your school nurse.

TURNER SCHOOL UNIFIED SCHOOL DISTRICT #202

Health Notification

This memo is to inform you that your child may have been exposed to the following:

Date of exposure _____

☐ Chicken Pox	☐ Fifth Disease	☐ German Measles
☐ Hepatitis	☐ Influenza	☐ Mononucleosis
☐ H1N1 Virus	☐ MRSA	☐ Mumps
☐ Pink Eye	☐ Ringworm	☐ Scabies
☐ Scarlet Fever	☐ Other _____	

For more information on any of these diseases, please visit the Wyandotte County Public Health Department website at http://www.wycokck.org/dept.aspx?id=488&menu_id=958 or contact your school nurse.

TURNER SCHOOL UNIFIED SCHOOL DISTRICT #202

Notificación de Salud

Este memorándum es para informarle que su hijo/a puede haber estado expuesto/a a lo siguiente:

Fecha de exposición _____

- ☐ varicella (chicken pox)
- ☐ Hepatitis
- ☐ H1N1 Virus
- ☐ Ojo rosado (pink eye)
- ☐ Scarlet Fever
- ☐ Fifth Disease
- ☐ La gripe (influenza)
- ☐ MRSA
- ☐ La tiña (ringworm)
- ☐ Otro: _____
- ☐ Sarampión alemán (German measles)
- ☐ Mononucleosis
- ☐ Paperas (mumps)
- ☐ La sarna (scabies)

Para más información sobre cualquier de estas enfermedades, por favor visite al Wyandotte County Public Health Department sitio de web: http://www.wycokck.org/dept.aspx?id=rii&menu_id=958 o esté en contacto con la enfermera de la escuela.

TURNER SCHOOL UNIFIED SCHOOL DISTRICT #202

Notificación de Salud

Este memorándum es para informarle que su hijo/a puede haber estado expuesto/a a lo siguiente:

Fecha de exposición _____

- ☐ varicella (chicken pox)
- ☐ Hepatitis
- ☐ H1N1 Virus
- ☐ Ojo rosado (pink eye)
- ☐ Scarlet Fever
- ☐ Fifth Disease
- ☐ La gripe (influenza)
- ☐ MRSA
- ☐ La tiña (ringworm)
- ☐ Otro: _____
- ☐ Sarampión alemán (German measles)
- ☐ Mononucleosis
- ☐ Paperas (mumps)
- ☐ La sarna (scabies)

Para más información sobre cualquier de estas enfermedades, por favor visite al Wyandotte County Public Health Department sitio de web: http://www.wycokck.org/dept.aspx?id=rii&menu_id=958 o esté en contacto con la enfermera de la escuela.

TURNER SCHOOL UNIFIED SCHOOL DISTRICT #202

Hearing Screening Results – 1st Notification

Name of Student: _____ Date: _____

Dear Parent(s) or Guardian:

As part of your school district's hearing conservation program, your child received a hearing screening at school. Hearing screenings are performed periodically to identify those students who may have a hearing disorder and in need of attention.

- ☐ Your child passed their hearing within normal limits for both ears.
- ☐ Your child did not pass their hearing at this time but will be rescreened at a later date.
- ☐ Your child did not pass their hearing and failure may be due to a medical concern. Please take the attached medical referral to your physician. Return the report to me after completion.

If you have any questions, please contact me at 913-288- _____.

Sincerely,

School Nurse

TURNER SCHOOL UNIFIED SCHOOL DISTRICT #202

Resultados del Tamizaje Auditivo – 1ra Notificación

Nombre del Estudiante: _____ Fecha: _____

Estimado(s) Padre(s) O Tutor:

Como parte del programa de conservación de la audición del distrito escolar, su hijo fue sometido a una prueba de audición en la escuela. Las pruebas de audición se realizan periódicamente para identificar a los estudiantes que tienen problemas de audición y que necesitan atención médica.

- ☐ Su hijo pasó la prueba y se descubrió que su audición está dentro de los límites normales en ambos oídos.
- ☐ Su hijo no pasó la primera prueba, pero se lo evaluará más adelante y se le informarán los resultados. Muchas veces, los niños fracasan en su primera prueba como consecuencia de problemas físicos o emocionales en el momento de la prueba.
- ☐ Su hijo no pasó la primera prueba de audición. Esta falla se puede deber a posibles problemas de salud y pueden derivar en problemas auditivos si no se controlan. Se recomienda entregar una copia del formulario de traslado al médico del niño. Una vez completado, el médico deberá entregarme el "Informe del Examen Médico".

Si tiene alguna pregunta, no dude en ponerse en contacto conmigo.

Atentamente,

Enferma escolar

TURNER SCHOOL UNIFIED SCHOOL DISTRICT #202

Hearing Aid Check Waiver

I have been informed that public law requires the schools to conduct a weekly listening check on hearing aids worn by students.

I am requesting that my son/daughter, _____ not have his/her hearing aid
(Name)
checked at school on a weekly basis. I understand that it is recommended my son/daughter's hearing aid be checked at home on a regular basis, as well as by their hearing aid dispenser and/or medical doctor.

_____
Parent/Guardian Name

_____ _____
Parent/Guardian Signature Date

TURNER SCHOOL UNIFIED SCHOOL DISTRICT #202

Hearing Aid Check Waiver

I have been informed that public law requires the schools to conduct a weekly listening check on hearing aids worn by students.

I am requesting that my son/daughter, _____ not have his/her hearing aid
(Name)
checked at school on a weekly basis. I understand that it is recommended my son/daughter's hearing aid be checked at home on a regular basis, as well as by their hearing aid dispenser and/or medical doctor.

_____
Parent/Guardian Name

_____ _____
Parent/Guardian Signature Date

TURNER SCHOOL UNIFIED SCHOOL DISTRICT #202

Hearing Aid Malfunction

Dear Parent or Guardian:

_____ 1. Your child's hearing aid is not working well in school today. The problem is believed to be related to:

____ Batteries ☐ Good ☐ Dead ☐ Weak

____ Ear Molds ☐ Needs to be cleaned
☐ Fittings needs to be checked
☐ Damaged

____ The hearing aid needs to be checked by your hearing aid dispenser as soon as possible.

_____ 2. Your child was not wearing a hearing aid today. Please check below to describe the problem and return the form to the school nurse.

☐ Hearing aid not working
☐ Hearing aid being replaced
☐ Hearing aid lost
☐ Ear mold problems
☐ No batteries

To acknowledge receipt of this information, please sign and date this form and return it to the school nurse.

_____ _____

Parent/Guardian Signature Date

TURNER SCHOOL UNIFIED SCHOOL DISTRICT #202

Follow Up Hearing Screening

Name of Student: _____ Date: _____

Dear Parent(s) or Guardian:

Your Child recently brought home a letter indicating that they did not pass the initial hearing screening at their school. Their hearing was again retested on _____.

Results of the follow-up screening indicated that your child:

- ☐ Your child passed the follow-up screening.
- ☐ Your child did not pass the follow up screening and should see a physician to rule out a medical problem. Please have the physician fill out the attached form and return to the school nurse.

If you have any questions, please feel free to contact the school nurse.

Sincerely,

School Nurse

TURNER SCHOOL UNIFIED SCHOOL DISTRICT #202

Hearing Medical Referral

Name of Student: _____ Date: _____

Dear Parent(s) or Guardian:

As part of your school district's hearing conservation program, your child received a hearing screening at his/her school. Your child did not pass the initial screening; therefore, his/her hearing was rescreened on _____. Again, your child did not successfully complete the screening.

It is important for your child's education that their hearing be further evaluated. Result indicated that the failure may be due to a possible medical concern which may lead to further hearing problems if not checked by a physician. It is recommended that a copy of the attached referral form be given to your child's physician, and the report returned to me after completion.

If you have any questions, please contact me at school.

Sincerely,

School Nurse

TURNER SCHOOL UNIFIED SCHOOL DISTRICT #202

Date _____

Student Name _____ School _____

Tympanometry Results:

Right Ear:

Pressure _____

Volume _____

Compliance _____

Left Ear:

Pressure _____

Volume _____

Compliance _____

PHYSICIAN'S REPORT OF MEDICAL FIDINGS

Findings and Recommendations (Check all that apply)

☐ Otitis Media ☐ Tonsil-Adenoid ☐ Noise Exposure ☐ Otosclerosis ☐ Cold

☐ Malingering ☐ Allergy ☐ Hereditary Loss ☐ Impacted Cerumen/Foreign Body

Other: _____

_____

Treatment Plan: _____

_____

Recommendations: _____

_____

_____

Physician Name

TURNER SCHOOL UNIFIED SCHOOL DISTRICT #202

Hearing Reevaluation

Name of Student: _____ Date: _____

Dear Parent(s) or Guardian:

Recently your child's hearing was evaluated at school. The results of this year's hearing test indicated that your child's hearing loss has not changed significantly during the past year. We will continue to monitor his/her hearing annually, and will inform you if there is a change in the status of your child's hearing.

If you have any questions or concerns regarding your child's hearing, please feel free to contact the school nurse.

Sincerely,

School Nurse

TURNER SCHOOL UNIFIED SCHOOL DISTRICT #202

Threshold Hearing Test

Name of Student: _____ Date: _____

Dear Parent(s) or Guardian:

Your child received a threshold hearing test at school on _____. Pure tone threshold test results indicated a mild hearing loss for the high pitches in _(2). At this time your child's hearing loss is mild and not considered medically or educationally significant.

Hearing loss which occurs in the high pitches generally affects the nerve or sensory system of the inner ear. This type of hearing loss is often caused or influenced by frequent exposure to loud noises including power tools, loud music, gun shots, firecrackers, snow blowers, etc. In order to prevent further damage, it is recommended that your child wear ear protection (ear plugs or muffs) when exposed to loud noise. Foam type ear plugs are inexpensive and can be purchased at drug stores and discount stores.

Your child's hearing will be monitored annually and you will be notified if there is any change in their status.

If you have any questions pertaining to these results, please feel free to contact your school nurse.

Sincerely,

School Nurse

TURNER UNIFIED SCHOOL DISTRICT 202

Christina Compton
DIRECTOR OF SPECIAL SERVICES
comptonc@turnerusd202.org

800 South 55th Street || Kansas City, Kansas 66106 || (P) 913 288-4181 (F) 913 288-3480 || www.turnerusd202.org

Employee Hepatitis B Form

Date: _____

The following individual is an employee of the Turner School District and is eligible to receive the Hepatitis B vaccination series.

Employee Name: _____

Wyandotte County Health Department
619 Ann
Kansas City, Kansas 66106
Phone: (913) 321-4803
Fax: (913) 321-7932 www.wycokck.org
Clinic Hours (subject to change) for walk-ins:
Monday through Friday- 8:30 a.m. to 5:00 p.m
Selected services available on Thursday evenings

Please send this form to Special Services.

The form must be faxed to Medical Records at Wyandotte County Health Department at (913) 573-6755 before the employee goes to the Wyandotte County Health Department for the Hepatitis B vaccination.

Division of Public Health
Curtis State Office Building
1000 SW Jackson St., Suite 300
Topeka, KS 66612-1368

Kansas Department of Health and Environment

Phone: 785-296-1086
www.kdheks.gov

Janet Stanek, Secretary

Laura Kelly, Governor

KANSAS CERTIFICATE OF IMMUNIZATIONS - FORM B

MEDICAL EXEMPTION

Student Name:_____ Birthdate: _____

Street Address: _____

City:_____ State:_____ Zip Code: _____

Parent/Guardian: _____

Telephone: _____

Medical exemption for the following vaccine(s):

( ) DTaP
( ) Tdap/Td
( ) Pertussis Only
( ) Polio
( ) MMR
( ) Hib
( ) Rotavirus
( ) Hepatitis A
( ) Hepatitis B
( ) Pneumococcal Conjugate
( ) Meningococcal Conjugate
( ) Varicella
( ) Human Papillomavirus
( ) Other: _____

I certify the physical condition of this child to be such that the inoculation(s) specified on this form would seriously endanger the life or health of this child.

Signature:_____ Date: _____

PLEASE PRINT

Name: _____

Street Address: _____

City:_____ State:_____ Zip Code: _____

Telephone: _____

Medical License Number:_____ State of Licensure: _____

A Medical Doctor (M.D.) or Doctor of Osteopathy (D.O.) must complete this affidavit. Annual medical exemptions shall be documented on this form and attached to the student's Kansas Certificate of Immunizations (KCI) form. Annual medical exemptions must be completed as long as the medical exemption is warranted.

TURNER SCHOOL UNIFIED SCHOOL DISTRICT #202

Religious Exemption from Immunization

Student's Name: _____ School Year: _____

My child is an adherent of a religious denomination whose religious teachings are opposed to such tests or inoculations that are required Kansas state law for school entry.

This form needs to be completed annually.

I am aware that in the event of an outbreak or suspected case of a vaccine-preventable disease, my child shall be excluded from school for the entire Incubation period of the disease.

Exclusion Periods (Incubation Time) for Various Immunizations:

Diphtheria- 6days
Pertusis- 20 days
Varicella (Chickenpox)-21 days
Mumps- 25 days
Rubella- 21 days
Tetanus- 21 days
Hepatitis B- 160 days
Hepatitis A- 50 days
Polio- 35 days
Measles- 12 days

Parent/Guardian Name (please print) _____

Parent/ Guardian Signature _____

Relationship to Child _____ Date _____

Division of Public Health
Curtis State Office Building
1000 SW Jackson St., Suite 300
Topeka, KS 66612-1368

Kansas Department of Health and Environment

Phone: 785-296-1086
www.kdheks.gov

Janet Stanek, Secretary

Laura Kelly, Governor

KANSAS SCHOOL KINDERGARTEN THROUGH GRADE 12 IMMUNIZATION REQUIREMENTS FOR 2024-2025 SCHOOL YEAR

Immunization requirements and recommendations for the 2024-2025 school year are based on the Advisory Committee on Immunization Practices (ACIP) and the Centers for Disease Control and Prevention (CDC) recommendations. The current recommended and minimum interval immunization schedules may be found on the CDC webpage. The best disease prevention is achieved by adhering to the recommended schedule. However, if a child falls behind, the catch-up schedule is implemented. To avoid missed opportunities, immunization providers may use a 4-day grace period, in most instances, per age and interval between doses. In such cases, these doses may be counted as valid.

K.S.A. 72-6261 - Kansas Statutes Related to School Immunizations Requirements and K.A.R. 28-1-20, published July 18, 2019 in the Kansas Register, defines the immunizations required for school and early childhood program attendance.

- **Diphtheria, Tetanus, Pertussis (DTaP/Tdap):** Five doses required. Doses should be given at 2 months, 4 months, 6 months, 15-18 months, and 4-6 years (prior to kindergarten entry). The 4th dose may be given as early as 12 months of age, if at least 6 months have elapsed since dose 3. The 5th dose is not necessary if the 4th dose was administered at age 4 years or older. A dose of **Tdap** is required at entry to 7th grade (11-12 years).

- **Hepatitis A (Hep A):** Two doses required. Doses should be given at 12-23 months with a minimum interval of 6 months between the 1st and 2nd dose.

- **Hepatitis B (Hep B):** Three doses required. Doses should be given at birth, 1-2 months, and 6-18 months. Minimum age for the final dose is 24 weeks.

- **Measles, Mumps, and Rubella (MMR):** Two doses required. Doses should be given at 12-15 months and 4-6 years (prior to kindergarten entry). Minimum age is 12 months and interval between doses may be as short as 28 days.

- **Meningococcal-Serogroup A,C,W,Y (MenACWY):** Two doses required. Doses should be given at entry to 7th grade (11-12 years) and 11th grade (16-18 years). For children 16-18 years, with no previous MenACWY, only one dose is required.

- **Poliomyelitis (IPV/tOPV):** Four doses required. Doses should be given at 2 months, 4 months, 6-18 months, and 4-6 years (prior to kindergarten entry). Three doses are acceptable if 3rd dose was given after 4 years of age **and** at least 6 months have elapsed since dose 2.

- **Varicella (Chickenpox):** Two doses are required. Doses should be given at 12-15 months and 4-6 years (prior to kindergarten entry). The 2nd dose may be administered as early as 3 months after the 1st dose, however, a dose administered after a 4-week interval is considered valid. No doses are required when student has history of varicella disease documented by a licensed physician.

Legal alternatives to school vaccination requirements are found in K.S.A. 72-6262.
In addition, to the immunizations required for school entry the following vaccines are recommended to protect students:

- **Human Papillomavirus (HPV):** Two doses *recommended* at 11 years of age or three doses if the series is started after 15 years.
- **Influenza** and **COVID-19:** Annual vaccination *recommended* for all ages ≥ 6 months of age.

Vaccination efforts by school and public health officials, immunization providers, and parents are key to the success of protecting our children and communities from vaccine preventable diseases. Thank you for your dedication.

TURNER SCHOOL UNIFIED SCHOOL DISTRICT #202

Inhaler Release Form

Name of Student: _____ Grade: _____ Date: _____

The above named student has been instructed in the proper use of _____.

We request he/she be permitted to carry the inhaler on his/her person as we consider him/her responsible. The student has been instructed in and understands the purpose and appropriate method and frequency in the use of the inhaler.

We, the undersigned, absolve the school or any responsibility in safeguarding the student's inhaler.

_____ _____

Physician's Signature Parent/Guardian's Signature

_____ _____

Physician's Address Parent/Guardian Address

_____ _____

Physician's Phone Parent/Guardian's Phone

It is strongly advised that each student leave an extra inhaler in the nurse's office in the event of a misplaced inhaler.

Thank you,

School Nurse

TURNER SCHOOL UNIFIED SCHOOL DISTRICT #202

Student Injury Report Form

Name of Student_____ Date of Birth ___/___/___ Grade _____

Student's Address _____
Street City State

Nature of Injury _____

Sent to Doctor _____ School ☐ Personal ☐ Hospital ☐

Name of Hospital Student Sent To _____

Name of Teacher in Charge _____

Date of Injury _____ Time of Incident _____ AM or PM (Please Circle)

Please check all applicable descriptions.

At School	Away From School	Traveling
☐ School Building	☐ School Sponsored Activity	☐ Traveling to School
☐ School Grounds	☐ School Supervised Activity	☐ Traveling from School
☐ During School Hours	☐ Engaged in Curricular Activity	☐ In School Operated Transportation
☐ After School Hours	☐ Engaged in Social Activity	☐ In School Chartered Transportation
☐ Lunch Hour		

If a school sponsored activity, was student a participant ☐ or an observer ☐ ?

If student was engaged in a sport event, was it intramural ☐ or interscholastic ☐ ?

Describe how and where it took place _____

_____

_____

_____
Signature Nurse, Coach, Teacher, Administrator

Date Insurance Forms sent to Hospital/Doctor _____ Date Insurance Claim Filed _____

TURNER SCHOOL UNIFIED SCHOOL DISTRICT #202

Permission for Over the Counter Medication

Name of Student: _____

Teacher: _____ Grade: _____

Medication:

Dosage:

Side Effects:

Medication:

Dosage:

Side Effects:

Medication:

Dosage:

Side Effects:

I hereby give permission for _____ to take over-the-counter medication above. I understand that I will furnish the above medication and it will be dispensed as directed on the medication label unless contraindicated. All medication must be in its own container and must be unopened.

Parent/Guardian Signature: _____ Date: _____

Nurse Signature: _____ Date: _____

TURNER SCHOOL UNIFIED SCHOOL DISTRICT #202

Request for Medication to be Administered
During School Attendance

Name of Student: _____ School: _____ Grade: _____

1. Medication _____ Dose _____ Time _____

Anticipated Side Effects _____

_____

Reason for Medication _____ Date Medication Started _____

Number of Days to be Administered at School _____ Duration of School Year YES ☐ NO ☐

2. Medication _____ Dose _____ Time _____

Anticipated Side Effects _____

_____

Reason for Medication _____ Date Medication Started _____

Number of Days to be Administered at School _____ Duration of School Year YES ☐ NO ☐

**Inhalers Only: An additional request form is needed to allow students to carry inhalers with them at all times.*

Physician Name _____ Phone (___) _____ - _____

Signature of Physician _____ Date _____

I hereby give my permission for the above named student to take the above prescription(s) at school as ordered. I understand that it is my responsibility to furnish this medication. I further understand that any school employee who administers any drug to my child in accordance with written instructions from physician or dentist shall not be liable for damages as a result of an adverse drug reaction suffered because of administering the drug.

☐ If checked, parent gives permission to exchange information with the above-mentioned physician/facility in order to obtain any needed information that would be considered relevant to the student's success in school.

Parent/Guardian Signature _____ Date _____

NOTE: The medication is to be brought to school by the parent or guardian in the original container, labeled by the pharmacy, or physician, stating the name of the medication, the dose and times to be administered. They entire form must be completed by parent and PHYSICIAN to administer prescribed medication during school hours.

TURNER SCHOOL UNIFIED SCHOOL DISTRICT #202

Request for Shot Records

☐ 1st notice ☐ 2nd notice ☐ 3rd notice

Student's Name: _____ Date of Birth: _____

School: _____ Grade: _____

School Nurse: _____ Date: _____

Your student's shot record at the school needs to be brought up to date. If your child has received any of the following vaccinations, please bring the record to school so that we can update it.

☐ DPT/Td /Tdap vaccine (Date of last dose _____)
☐ Tdap
☐ Polio / IPV / OPV
☐ Hepatitis B
☐ Hib
☐ MMR vaccine
☐ Varicella (Chicken pox)
☐ Mengicoccal (MCV4)
☐ Hepatitis A
☐ PCV7

☐ We need a copy of your child's shot records – It is Kansas State Law.
☐ Physical needed

Your student will be given until _____to submit the requested records to the school, or they will not be able to attend.

***RECORDS CAN BE FAXED TO THE SCHOOL AT 913-288 - _____**

Required Vaccines

Ages 4 Years and Younger	
DTP	4 doses
IPV (Polio)	3 doses
MMR	1 dose
Varicella (Chicken Pox)	1 dose
Hepatitis A	2 doses
Hepatitis B	3 doses
HIB/PCV	4 doses
Grades 3-12	
Varicella (Chicken Pox)	2 doses
Tdap	1 dose
IPV (Polio)	4 doses
MMR	2 doses

Kindergarten – 1st Grade	
DTP	5 doses
IPV (Polio)	4 doses
MMR	2 doses
Varicella (Chicken Pox)	2 doses
Hepatitis A	2 doses
Hepatitis B	3 doses
7th Grade	
Mengicoccal	1 dose
Tdap	1 dose
11th Grade	
Mengicoccal	2 doses

TURNER SCHOOL UNIFIED SCHOOL DISTRICT #202

Solicitud de Registros de Vacunación

☐ 1er Aviso ☐ 2do Aviso ☐ 3er Aviso

Nombre del Estudiante: _____ Fecha de Nacimiento: _____

Escuela: _____ Grado: _____

Enfermera de la Escuela: _____ Fecha: _____

Es necesario actualizar el registro de vacunas de su estudiante en la escuela. Si su hijo ha recibido alguna de las siguientes vacunas, traiga el registro a la escuela para que podamos actualizarlo.

☐ Vacuna de DPT/Td /Tdap (Fecha de la ultima dosis_____)
☐ Tdap
☐ Polio / IPV / OPV
☐ Hepatitis B
☐ Hib
☐ Vacuna de MMR
☐ Varicela (Chicken pox)
☐ Meningococo (MCV4)
☐ Hepatitis A
☐ PCV7

☐ Necesitamos una copia de los registros de vacunas de su hijo. Es la Ley del Estado de Kansas.
☐ Necesitamos el Físico

Su estudiante tendrá hasta _____ para presentar los registros solicitados a la escuela, o no podrá asistir a la escuela hasta que los proporcione.

***LOS EXPEDIENTES SE PUEDEN ENVIAR POR FAX A LA ESCUELA Al 913-288 - _____**

Vacunas Requeridas

Edades de 4 Años y Menos.	
DTP	4 dosis
IPV (Polio)	3 dosis
MMR	1 dosis
Varicela (Chicken Pox)	1 dosis
Hepatitis A	2 dosis
Hepatitis B	3 dosis
HIB/PCV	4 dosis
Grades 3-12	
Varicela (Chicken Pox)	2 dosis
Tdap	1 dosis
IPV (Polio)	4 dosis
MMR	2 dosis

Jardín de infancian – 1er Grado	
DTP	5 dosis
IPV (Polio)	4 dosis
MMR	2 dosis
Varicela (Chicken Pox)	2 dosis
Hepatitis A	2 dosis
Hepatitis B	3 dosis
7th Grade	
Meningococo	1 dosis
Tdap	1 dosis
11th Grade	
Meningococo	2 dosis

SEIZURE ACTION PLAN

Effective Date _____

THIS STUDENT IS BEING TREATED FOR A SEIZURE DISORDER. THE INFORMATION BELOW SHOULD ASSIST YOU IF A SEIZURE OCCURS DURING SCHOOL HOURS.

Student's Name: _____ Date of Birth: _____

Parent/Guardian: _____ Phone: _____ Cell: _____

Treating Physician: _____ Phone: _____ Cell: _____

Significant medical history: _____

SEIZURE INFORMATION:

Seizure Type	Length	Frequency	Description

Seizure triggers or warning signs: _____

Student's reaction to seizure: _____

BASIC FIRST AID: CARE AND COMFORT:

(Please describe basic first aid procedures)

Does student need to leave the classroom after a seizure? ☐ YES ☐NO

If YES, describe process for returning student to classroom.

Basic Seizure First Aid:
- ✓ Stay calm & trach time
- ✓ Keep child safe
- ✓ Do not restrain
- ✓ Do not put anything in mouth
- ✓ Stay with child until fully conscious
- ✓ Record seizure in log

For tonic-clonic (grand mal) seizure:
- ✓ Protect head
- ✓ Keep airway open/watch breathing
- ✓ Turn child on side

EMERGENCY RESPONSE:

A "seizure emergency" for this student is defined as:

Seizure Emergency Protocol: *(Check all that apply and clarify below)*

- ☐ Contact school nurse at _____
- ☐ Call 911 for transport to _____
- ☐ Notify parent or emergency contact
- ☐ Notify doctor
- ☐ Administer emergency medications as indicated below
- ☐ Other

A seizure is generally considered an emergency when::
- ✓ A convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- ✓ Student has repeated seizures without regaining consciousness
- ✓ Student has a first time seizure
- ✓ Student is injured or has diabetes
- ✓ Student has breathing difficulties
- ✓ Student has a seizure in water

TREATMENT PROTOCOL DURING SCHOOL HOURS: (include daily and emergency medications)

Daily Medications	Dosage & Time of Day Given	Common Side Effects & Special Instructions

Emergency / Rescue Medication _____

_____

Does student have a **VAGUS Nerve Stimulator** (VNS)? ☐ YES ☐ NO

If YES, describe magnet use _____

_____

SPECIAL CONSIDERATIONS & SAFETY PRECAUTIONS: *(regarding school activities, sports, fieldtrips, etc…)*

_____

_____

Physician Signature: _____ Date: _____

Parent Signature: _____ Date: _____

To Ophthalmologist or Optometrist (Please Return to School)

To be completed by school

Name of School _____ School District _____

School Address: Street _____ City _____ Zip Code _____

Parent/Guardian Name _____

Parent Address: Street _____ City _____ Zip Code _____

Performance on Vision Screening Test _____ _____
Date of Test Signature of Screener

Type of Acuity Testing: _____

SCREENING (check appropriate box)
☐ with glasses ☐ without glasses

1. Distance Vision Acuity
   ☐ right eye ☐ left eye ☐ both
2. Near Vision Acuity
   ☐ right eye ☐ left eye ☐ both
3. Plus Lens Test
   ☐ pass ☐ fail
   ☐ right eye ☐ left eye ☐ both
   Power of lens used _____
4. Cover/Uncover
   ☐ right eye ☐ left eye ☐ both
5. Color Discrimination
   ☐ pass ☐ fail
6. Titmus Fly Test
   ☐ pass ☐ fail
7. Corneal Light Reflex
   ☐ pass ☐ fail
6. Near Point of Convergence
   ☐ pass ☐ fail

Indications of vision difficulty (include behavior, appearance, or complaints) or explanation of screening: _____

To be completed by Ophthalmologist or Optometrist

Diagnosis (primary and secondary) _____

ACUITY	Right Eye	Left Eye	Both Eyes
Distance: Vision acuity without glasses	_____	_____	_____
Vision Acuity after correction	_____	_____	_____
Near: Vision acuity without glasses	_____	_____	_____
Vision Acuity after correction	_____	_____	_____

Is there a filed limitation? _____ What is the widest diameter (in degrees) of remaining vision field? ☐ right eye ☐ left eye ☐ both

Recommendations of Examiner
Restriction of physical activity is required _____ Specify _____
Lighting requirements: ☐ Average ☐ Better than Average ☐ Less than Average
Recommend glasses: (check appropriate items) ☐ all the time ☐ for near ☐ none
Prognosis: ☐ Stable ☐ Deteriorating ☐Better than Average ☐ Uncertain
Comments: _____

Release of Information: I hereby authorize the release of the results and recommendations from this examination to school officials and educational health officials.

_____
Parent Signature

_____
Date

Examination was by:
☐ Ophthalmologist ☐ Optometrist ☐ Other _____

Date of next visit _____

Address _____

_____ _____
Signature Date

TURNER SCHOOL UNIFIED SCHOOL DISTRICT #202

Vision Test Results

To the parent/guardian of: _____

Your child's vision has been tested in our school-screening program. The findings are as follows:

☐ Within normal limits
☐ Referral to Ophthalmologist/Optometrist

Please give the attached referral form to the examining doctor. The report of examination should be returned to the school.

Sincerely,

_____ _____
School Nurse Date

TURNER SCHOOL UNIFIED SCHOOL DISTRICT #202

Vision Test Results

To the parent/guardian of: _____

Your child's vision has been tested in our school-screening program. The findings are as follows:

☐ Within normal limits
☐ Referral to Ophthalmologist/Optometrist

Please give the attached referral form to the examining doctor. The report of examination should be returned to the school.

Sincerely,

_____ _____
School Nurse Date