

ADMINISTRATIVE REGULATION

1062.2 Administering Medicines to Students

School personnel must be advised of medication to be taken at school. Except as directed by a physician, the medication must be left with the building principal or his/her designee who will supervise its administration.

A record must be kept of all children receiving medication. This record must be accessible in the nurse's office.

Purpose

This regulation provides the framework for staff members to follow when administering medication to students.

Procedures and Responsibilities

1. Long-term administration of prescription medication by school personnel requires a *Request for Administration of Medication* form signed by a qualified physician.

All long-term medication must be delivered by the parent/guardian, or other adult that the parent/ guardian designates, to the nurse or the principal's designee. At that time, the number of pills will be counted, with documentation signed by the nurse or principal's designee and the parent/guardian/adult designee.

Any long-term medication brought to school by a student will be held in the nurse's office and will not be administered until the parent/guardian/adult designee is available to document receipt of the medication.

At the end of the school year, or if a medication is discontinued, the parent/guardian/adult designee will pick-up the medication from school. If the parent/guardian does not want the medication returned, the school nurse or principal's designee and one other staff member will count and dispose of the medication, and document the action taken.

2. Short-term administration of prescription medication by school personnel requires that the medication be sent to school in its original container with the student's name on the printed prescription label and a note from the parent authorizing the administration.
3. Non-prescription medication may be self-administered by a student, but the student may have only the amount required for that school day.
4. Non-prescription medication may be administered by school personnel with either:
  - a. a note from a physician, or
  - b. telephone approval from a physician.

Non-nursing school personnel who are designated to administer medication will be provided an inservice on the procedure/s to follow.

Approved: August 15, 1996

Fairbanks NSB School District  
520 Fifth Avenue  
Fairbanks, Alaska 99701-4756



# FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

520 Fifth Avenue Fairbanks, Alaska 99701-4756 (907) 452-2000



## ABSENCE OR COMPLEX PARTIAL SEIZURE (Individual Health Care Plan)

FOR \_\_\_\_\_ DOB \_\_\_\_\_

Written on \_\_\_\_\_ by \_\_\_\_\_, RN Phone \_\_\_\_\_

\_\_\_\_\_ has a health condition you as his/her teacher needs to be aware. The description of this problem, as well as emergency care and individual considerations are stated below. Keep this information available for substitute teachers. Please contact me if you have any questions.

### Medical Diagnosis / Condition: Generalized Seizure

A generalized seizure is a sudden occurrence of reduced level of consciousness. During seizure activity occurring at school, the student needs immediate assistance from school personnel to maintain the student's safety.

### Signs / Symptoms:

1. Sudden lapse of consciousness for 2 to 10 seconds.
2. Usually a blank facial expression that may be accompanied by certain movements such as repeated eye blinking or lip smacking.
3. There is no convulsion or fall.
4. Student resumes activity as if the seizure had not occurred.

### Action:

1. Speak calmly and reassuringly to the student (and others around the student if necessary).
2. Guide student gently away from obvious hazards.
3. Stay with the student until seizure is over.
4. Bring student to health room/office when seizure is over, allow him/her to rest.
5. DO NOT restrain student; seizure must run its course.
6. Be prepared to describe pattern of seizure.
7. Reassure student and classmates.
8. Notify parent/guardian.
9. Record seizure on flow sheet.

### Individual Consideration:

Seizure activity may occur as a result of blinking lights, oscillating fans, rolling TV screens, or other visual stimuli. \_\_\_\_\_

Parent/Guardian \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Physician \_\_\_\_\_ Phone \_\_\_\_\_ Hospital \_\_\_\_\_

Other Contact Person \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_



FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

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**BLOOD PRESSURE REFERRAL FORM**

Date \_\_\_\_\_

Dear Parent/Guardian of \_\_\_\_\_

As part of our routine Health Screening, we have taken your student's blood pressure. Because of a High \_\_\_\_\_/Low \_\_\_\_\_ initial reading, we have rechecked his/her B/P several times. Since the Blood Pressure was still High \_\_\_\_\_/Low \_\_\_\_\_, we are sending you this referral form. The results of these readings and their dates are listed below. We recommend that you contact your doctor/HCP with this information for follow up. If you have any questions, please feel free to call the School Nurse at \_\_\_\_\_, between the hours of \_\_\_\_\_ and \_\_\_\_\_, Monday through Friday.

Please inform the School Nurse of any follow up treatment required so that we may provide the best care for your student at school. Thank you for your assistance in this important matter.

BP \_\_\_\_\_

BP \_\_\_\_\_

BP \_\_\_\_\_

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School Nurse





## FAIRBANKS NORTH STAR BOROUGH SCHOOL ISTRICT

520 Fifth Avenue Fairbanks, Alaska 99701-4756 (907) 452-2000

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### CHICKEN POX

Dear Parent/Guardian:

A student in your child's classroom has chicken pox. The following is information regarding chicken pox.

Chicken pox is a very common childhood illness without serious complications to healthy children. However, it is highly contagious and is marked by eruptions on the skin and mucous membranes. One attack usually confers immunity.

Symptoms may include slight fever, fatigue, lack of appetite, and headache. An itchy rash begins as a flat area rapidly progressing to lesions that resemble insect bites. These lesions develop into blisters filled with amber-colored fluid. The rash usually begins on the back, chest, and face.

Chicken pox is transmitted primarily from the respiratory tract and also by discharge from skin lesions. After exposure, it may take 14 to 21 days for a rash to develop. It is contagious 1 day before the rash appears to 5 or 6 days after onset of the rash.

**Children with chicken pox may NOT return to school until ALL lesions are crusted and dry. They must be checked by the school nurse prior to returning to school.**

**Treatment includes use of calamine lotion to help control itching. Consult your family physician as necessary.**

### **!! DO NOT GIVE ASPIRIN !!**

**Chicken pox is a viral illness, and use of aspirin may lead to Reye's Syndrome.**

Call my office at \_\_\_\_\_ if you have any questions.

\_\_\_\_\_  
School Nurse

\_\_\_\_\_  
Date



FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

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## Child Harm (Abuse and Neglect) Affidavit of Participation in Training For FNSBSD Staff

I, \_\_\_\_\_, certify that on \_\_\_\_\_,  
(employee name, please print) (date)  
viewed a training session on child abuse and neglect. The session covered the following topics as dictated by  
Chapter 205, SLA 90:

1. laws relating to child abuse and neglect
2. techniques for recognition and detection of child abuse and neglect
3. agencies/organizations within the state that offer aid or shelter to victims and the families of victims of child abuse and neglect
4. procedures for required notification of suspected abuse or neglect
5. role of a person required to report child abuse or neglect and the school district's role after the report has been made
6. brief description of the manner in which cases of child abuse or neglect are investigated by the Division of Family and Youth Services and law enforcement agencies after a report of suspected abuse or neglect.

Signature

\_\_\_\_\_  
Date

Social Security Number



FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

520 Fifth Avenue Fairbanks, Alaska 99701-4756 (907) 452-2000



## COLOR VISION DEFICIENCY

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Dear Parent/Guardian of \_\_\_\_\_:

During the health screening, your child was identified as having visual color deficiency. This is not a serious problem and does not require further testing. Your child's teacher has been notified.

The following article explains more about color deficiency. If you have any questions or concerns, call me at \_\_\_\_\_.

Sincerely,

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### COLOR VISION DEFICIENCY

**Definition:** Color deficiency (blindness) is the inability to distinguish between primary colors. Color vision is a function of the central cones in the retina of the eye. When stimulated by light, the cones transmit impulses to the brain. Deficiencies range from mild to severe. In any given classroom, 5% of the students may have color deficiencies.

**Etiology:** Color blindness is a defect inherited as an x-linked, recessive trait that primarily affects the male population. Occasionally, color deficiency may be acquired from injury, disease, or certain drugs; however, most incidence is hereditary.

**Signs, Symptoms, and History:** 1. Unable to discriminate colors 2. Difficulty learning primary colors  
3. Family history of color deficiency 4. Fails pseudo-isochromatic screening.

**Treatment:** 1. No known treatment 2. Parents, teachers, and other professionals working with a student must be aware of the color deficiency 3. Adolescent needs counseling regarding color difficulties that may be related to high school and college course work, as well as vocational plans and possible military goals.

**Additional Information:** The color-defective male inherits his deficiency from his mother. Heterozygous females (carriers) have one recessive gene for color deficiency and one dominant gene for normal color vision. The male Y chromosome does not carry a color discrimination gene.

There are three classifications of color blindness: 1. proton - red, blue, and green color weakness - the most common type; 2. deuton - green, purple color weakness; 3. triton - yellow, blue color weakness - very rare. Traffic lights in most areas in the United States are not a problem because of the consistent placement of colors. Also, the red and green in the traffic lights are not pure colors.



## Communicable Illnesses

Date \_\_\_\_\_

Dear Parent/Guardian:

You do not want your child to miss school; but neither do you want to send a sick child to school and endanger his/her health and other children as well. When should your child stay home from school? Here are a few guidelines you to follow:

\* **Runny nose or "leaky faucet"** is the way many children respond to pollen, dust, chalk, or simply a change of season. If it is not a cold, then it is an allergy and allergies are not contagious. Do not keep the child home.

\* **Bad cough or cold symptoms** can indicate a severe cold, bronchitis, flu, or even pneumonia. Some children suffer one cold after another all winter long and a "run-of-the-mill" cold should not be a reason to miss school. But if your child is not acting right, has difficulty breathing, or is becoming dehydrated, it could be serious. Check with your pediatrician right away.

\* **Diarrhea and vomiting** make children very uncomfortable, and being near a bathroom becomes a top priority. If your child has repeated episodes of diarrhea and vomiting accompanied by fever, a rash, or general weakness, consult a doctor and keep you child out of school until the illness passes. However, a single episode of diarrhea or even vomiting unaccompanied by any other symptoms, may not be reason enough for your child to miss school. BUT...please make sure we know how to reach you or another responsible adult during the day in case diarrhea and/or vomiting occurs and your child needs emergency attention. (This is an important rule to follow whenever you send your child to school with any of the symptoms mentioned here.)

\* **Fever** is an important symptom. When it occurs along with a sore throat, earache, nausea, listlessness, or rash, your child may be carrying something very contagious. Most pediatricians advise parents to keep children home during the course of a fever, 100 degrees or higher, and for an additional 24 hours after the fever has passed.

\* **Strep throat and scarlet fever** are two highly contagious conditions caused by a streptococcal (bacterial) infection. They usually start with a sore throat and high fever. Approximately 12 to 48 hours after the onset of scarlet fever, a rash will also appear. A child with either strep throat or scarlet fever should be kept home and treated with antibiotics as prescribed by a physician. After 24 hours on antibiotics, a child is usually no longer contagious and may, with a doctor's permission, return to school.

\* **Chicken pox**, a viral disease, is not life-threatening to children, but is very uncomfortable and extremely contagious. If your child has a fever, is itching, and pink or red spots appear on the back, chest, and/or face, the chances are good it is chicken pox. Please tell us if it is; it is important the school knows this information. Keep your child home until the last spot has dried and crusted over.

\* **Conjunctivitis or pink eye** is highly contagious and uncomfortable, so take heed when your child complains of an eye or eyes burning, itching, and producing a whitish discharge. Minor cases (caused by a virus) and severe cases (caused by bacteria) require treatment with prescription eyedrops. Best to keep you child home until your doctor says it is all right to return or until 24 hours after treatment has begun.

\_\_\_\_\_  
Nurse

\_\_\_\_\_  
Phone

\_\_\_\_\_  
School



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FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

520 Fifth Avenue Fairbanks, Alaska 99701-4756 (907) 452-2000



**FETAL ALCOHOL SYNDROME/FETAL ALCOHOL EFFECTS  
(FAS/FAE) TRAINING  
Affidavit of Participation**

I, \_\_\_\_\_, certify that on \_\_\_\_\_,  
(employee name, please print) (date)

viewed a training session on FAS/FAE. The program covered the following topics as dictated by AS 14.20.680:

1. **Recognize the extent of the FAS/FAE problem and how it affects all of us (education, economics, society).**
2. **Increase our awareness of medical and psychological characteristics of FAS/FAE and other drug-affected children.**
3. **Provide accurate information to promote prevention of fetal drug-affected children.**
4. **Identify techniques and methodologies that address the educational needs of FAS/FAE children in our classrooms.**
5. **Be aware of family issues related to FAS/FAE and other drug-affected children.**

The presenters were Vicki Hild, M.S.P.H., Alaska Area Native Health Service; Diane Malbin, M.S.W., private practice; and Donna Burgess, Ph.D., University of Washington, Experimental Education Unit.

Signature

\_\_\_\_\_  
Date

Social Security Number



## FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

520 Fifth Avenue Fairbanks, Alaska 99701-4756 (907) 452-2000

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### **FIFTH DISEASE**

Dear Parent/Guardian:

A case of Fifth Disease, also known as Slap Cheek Disease, has occurred in your child's classroom. Fifth Disease is a viral rash that usually occurs in children two to twelve years old. There are two characteristic stages. In the first stage, usually after a few days of low-grade fever and symptoms of a mild cold, a rash appears on the face. The face has a "slapped cheek" appearance. The facial rash fades within four days. The second stage begins after the onset of the facial rash and is a rash on the extremities. When the rash begins to fade, it will appear lace-like. The rash may last several days or weeks. Sunlight, temperature extremes, and exercise may cause reappearance or increase in rash symptoms over a period of a few days or even several months.

Fifth Disease is self-limiting and does not require treatment. The disease is most likely transmitted by direct contact with infected droplets similar to a cold. The incubation period is 4 - 18 days. Children should be kept home if a fever does occur. It is difficult to stop the spread of Fifth Disease due to the fact that children are contagious before they realize they are sick, 3-14 days before symptoms appear.

Although there is a little skin irritation due to the rash, the average child will feel fine. Adolescents or adults may experience joint pain or swelling. There are usually no long-term side effects from the disease. Children with suppressed immune systems or blood disorders and pregnant women are at risk for further complications. Pregnant women should notify their health care provider if there is exposure or if a rash develops. If you have any questions, call me.

Sincerely,

\_\_\_\_\_  
School Nurse

\_\_\_\_\_  
Phone





# FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

520 Fifth Avenue Fairbanks, Alaska 99701-4756 (907) 452-2000



## COLD

Date \_\_\_\_\_

Dear Parent/Guardian:

\_\_\_\_\_ was seen by the school nurse for symptoms of a cold. Here are some things that you can do at home to help your child feel better.

- \* **Have your child drink at least 8 glasses of clear liquids like fruit juices and/or water. Warm broth is also good because it may help thin the thick mucous. Since milk may cause mucous to thicken, you may want to limit the amount of milk your child drinks during this time.**
- \* Salt water nose drops may be helpful for a stuffy nose, especially at bedtime. Salt water drops are made by mixing \_ teaspoon of salt in \_ cup of warm water. Use two or three drops in each nostril.
- \* **For the relief of headache, sore throat, and/or fever, you may use a nonaspirin product such as Tylenol. DO NOT USE ASPIRIN!**
- \* **Keep your child home from school if he/she has a fever of 101 degrees or higher.**
- \* **See your doctor if your child does not get better in a few days or if the fever increases.**

\_\_\_\_\_  
School Nurse

\_\_\_\_\_  
Phone

**Healthy Children Learn Better!**

*Fairbanks North Star Borough School District nurses are doing their part.  
Thank you for doing yours.*



# FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

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## FROSTBITE

Dear Parent/Guardian:

I saw \_\_\_\_\_ in the nurse's office today for frostbite of the \_\_\_\_\_. Frostbite is injury to tissues from freezing. Symptoms are cold, white, tingly or numb skin, itching, or stiffness of the affected area. The nose, earlobes, cheeks, hands, and feet are most affected. Once frostbite has occurred, there will always be increased sensitivity to cold.

**Treatment:** Rewarming of an affected part is necessary when all danger of refreezing has past. Warm, wet compresses of 104-108°F or a warm water bath are good to use. Use warm, tepid water from of 100-104°F to slowly rewarm the body. Avoid friction to the area.

**Follow-up:** Mild frostbite may be cared for at home. The area may be red or slightly swollen after rewarming.

Moderate to severe frostbite should be seen by a physician. Moderate frostbite will develop blisters within 24-48 hours. This is called second degree frostbite.

**Prevention:** To prevent frostbite, children should wear a hat, scarf or face mask, boots, snow pants, and heavy mittens especially when the outside temperature is 10 degrees or lower.

Your child (**was / was not**) wearing \_\_\_\_\_ when the frostbite occurred. Please help your child be aware of the danger of not dressing properly for the weather.

Comments:

\_\_\_\_\_  
School Nurse

\_\_\_\_\_  
Date

\_\_\_\_\_  
Phone



# FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

520 Fifth Avenue Fairbanks, Alaska 99701-4756 (907) 452-2000



## GRAND MAL SEIZURE

FOR \_\_\_\_\_ DOB \_\_\_\_\_

Written on \_\_\_\_\_ by \_\_\_\_\_, RN Phone \_\_\_\_\_

\_\_\_\_\_ has a health condition you as his/her teacher needs to be aware.

The description of this problem, as well as emergency care and individual considerations are stated below. Keep this information available for substitute teachers. Please contact me if you have any questions.

**Medical Diagnosis / Condition:** Grand Mal Seizure

A grand mal seizure is a sudden occurrence of reduced level of consciousness and random “jerking” movement of the muscles. During seizure activity occurring at school, students need immediate assistance from school personnel to maintain the student’s safety.

**Signs / Symptoms:**

- |                                                         |                                              |
|---------------------------------------------------------|----------------------------------------------|
| 1. Aura _____                                           | 5. Dilation of pupils                        |
| 2. Generalized convulsions involving entire body        | 6. Loss of consciousness; may fall to ground |
| 3. Facial pallor followed by blue discoloration of skin | 7. Involuntary loss of urine or feces        |
| 4. Labored (noisy) breathing                            | 8. Other _____                               |

**Individual Consideration:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Parent/Guardian \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Physician \_\_\_\_\_ Phone \_\_\_\_\_ Hospital \_\_\_\_\_

Other Contact Person \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Revised: November 2003



## FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

520 Fifth Avenue Fairbanks, Alaska 99701-4756 (907) 452-2000

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### HAND, FOOT, AND MOUTH DISEASE

Date \_\_\_\_\_

Dear Parent/Guardian:

This is to inform you that we have had one case of “Hand, Foot, and Mouth Disease (Coxsackie Virus)” which is an illness caused by a virus, usually in children under the age of ten. The disease is more common in the summer and early autumn. Symptoms are a fever (up to 102 degrees F) and in a couple of days sores are discovered in the mouth and red spots or blister-like sores appear on the hands and feet. The rash does not itch. The disease runs its course in 7-10 days. Pharyngitis is common due to the ulcers and sores in the mouth.

It is highly contagious. The student/child **should stay home until the last sore is crusted over, there are no new lesions (similar to chicken pox procedure), and the child has been fever-free for 24 hours.** The virus is shed in the fluid of the sores and in the stool.

Treatment is to treat the symptoms (Tylenol for the fever, etc.). At home, do frequent **handwashing; do not share food, utensils, or glasses; and wash down counters, toys and bedding with household cleaners.** You need to exclude the child from daycare, school, and public programs.

Sincerely,

\_\_\_\_\_  
School Nurse

\_\_\_\_\_  
Phone

Web site for further information:

<http://www.lpch.org/HealthLibrary/ParentCare/Topics/SkinWidespreadSymptoms/HandFootMouthDisease.html>





FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

520 Fifth Avenue Fairbanks, Alaska 99701-4756 (907) 452-2000

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## HEAD INJURY INSTRUCTION SHEET FOR PARENTS

Dear Parent/Guardian:

Date \_\_\_\_\_

\_\_\_\_\_, received a blow to the head today at \_\_\_\_\_ (time).  
**Your child was seen in the nurse's office and had no problems at that time. His/her blood pressure was \_\_\_\_\_, pulse \_\_\_\_\_, respiration \_\_\_\_\_, and pupil size \_\_\_\_\_. You should watch for any of the following symptoms for 24 - 48 hours, and consult a physician or the emergency room if any symptoms appear.**

1. unusual behavior such as being confused, breathing irregularly, dizziness, agitation
2. severe headache
3. nausea or vomiting
4. double vision or blurred vision
5. loss of muscle coordination (falling down, walking strangely, staggering)
6. unusual sleepiness, drowsiness, or loss of consciousness
7. bleeding or discharge from the ear or nose
8. convulsions or seizures
9. unequal pupils (pupils are different sizes)

**Check your child carefully at bedtime, and awaken him/her at midnight to see if he/she is behaving normally. In a small number of cases, signs of serious injury may appear later. Avoid medication for a headache until you have consulted your physician.**

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
School Nurse

\_\_\_\_\_  
Phone

**➔ Parent/Guardian – Please contact the school nurse if medical treatment was needed.**



### HEALTH HISTORY SURVEY

Student \_\_\_\_\_ DOB \_\_\_\_\_ School \_\_\_\_\_

Father \_\_\_\_\_ Home Phone \_\_\_\_\_

Mother \_\_\_\_\_ Work Phone \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

Please fill out the information requested below. If there are any changes in your child's health status during the year, please inform the school nurse.

- |                                                                          |                                              |                                               |                                          |
|--------------------------------------------------------------------------|----------------------------------------------|-----------------------------------------------|------------------------------------------|
| <input type="checkbox"/> ADD/ADHD                                        | <input type="checkbox"/> Depression          | <input type="checkbox"/> Frequent Sore Throat | <input type="checkbox"/> Seizures/Spells |
| <input type="checkbox"/> Allergies (List)                                | <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Speech Problem       | <input type="checkbox"/> Dental Problems |
| <input type="checkbox"/> Asthma                                          | <input type="checkbox"/> Hearing/Ear Problem | <input type="checkbox"/> Stomachaches         | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> Bee Sting Allergy                               | <input type="checkbox"/> Chickenpox          | <input type="checkbox"/> Heart Condition      | <input type="checkbox"/> Other _____     |
| <input type="checkbox"/> Urinary Tract Problems                          |                                              | <input type="checkbox"/> Orthopedic Problems  |                                          |
| <input type="checkbox"/> Diabetes (Please complete a Diabetic Care Plan) |                                              |                                               |                                          |

Please explain any condition that is indicated above: \_\_\_\_\_

When was the last time the condition/problem(s) was noticeable, i.e seizure date, insulin reaction date: \_\_\_\_\_

When was the last time the condition(s) was evaluated by a physician? Date \_\_\_\_\_

Physician/Clinic: \_\_\_\_\_

Is physical education activity limited or periodically limited? \_\_\_\_\_ Yes \_\_\_\_\_ No

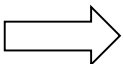
Is medication needed for any condition? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please complete:

Name of condition \_\_\_\_\_ Name and Dosage of Medication \_\_\_\_\_

If you feel that a detailed medical history questionnaire would assist the nurse and school staff, please ask the school nurse for the Medical History Questionnaire form.

Please complete the Over-The-Counter Medication Permission Form on the back of this page



I give my consent for \_\_\_\_\_ to have a tuberculin test (PPD) as required by state law.

**I also give my consent for the FNSB school district personnel (nurse) to share Immunization records with clinics, hospitals, physicians, and other medical facilities as needed.**

\_\_\_\_\_  
Parent/Guardian Signature



**OVER-THE-COUNTER MEDICATION PERMISSION FORM**

Student \_\_\_\_\_ Date \_\_\_\_\_

Date of Birth \_\_\_\_\_ Teacher \_\_\_\_\_ Grade \_\_\_\_\_

As the parent/guardian of the above named student, I have reviewed the Fairbanks North Star Borough School District standing orders for over-the-counter medications. I understand that in the event my (elementary-age) child becomes ill at school, school staff will make a reasonable effort to contact me before giving any medications. (Note: The school nurse may not need to contact parents for Middle and High school students). If I cannot be reached:

(Check all that apply)

- School nurse has my permission to give **ONLY** (PLEASE CHECK ALL APPROPRIATE BOXES) the following over-the-counter medications as needed per FNSBSD medical standing orders:
  - Acetaminophen (such as Tylenol) for pain or fever (dose based on the child's weight)
  - Ibuprofen (such as Advil) for pain or fever (dose based on the child's weight)
  - Chewable antacids (such as Tums) for upset stomach or heartburn
  - Diphenhydramine (such as Benadryl) for allergic reactions

School nurse does **NOT** have my permission to give any over-the-counter medications to my child.

My child is **NOT ALLERGIC** to any medications.  My child is **ALLERGIC** to the following medications:

\_\_\_\_\_  
\_\_\_\_\_

Please read and initial in front of the statement below:

**\_\_\_\_\_ If my child requires short-term prescription medication(s) (i.e antibiotics, eye drops, etc for less than 2 weeks), I will provide written or verbal permission to the school nurse. Medication(s) must be sent in labeled (original) container with student's name, dosage and administering information on label. Please Note: All prescription pain medication, narcotic or controlled medications must be delivered by a parent/guardian to the school nurse as per AR 1062.2.**

Signature \_\_\_\_\_ Date \_\_\_\_\_

Please provide an alternate means whereby the school staff may contact you:

\_\_\_\_\_  
Phone number/cell phone number/ work number/ neighbor/friend contact number

# FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

520 Fifth Avenue Fairbanks, Alaska 99701-4756 (907) 452-2000



## HEPATITIS A

Date \_\_\_\_\_

Dear Parent/Guardian:

This week a student in your child's class was diagnosed with Hepatitis A, which is a viral infection that causes the liver to become inflamed. This student has not attended school since the first symptoms were discovered and will not be returning until they are cleared medically.

Hepatitis A is a communicable disease, but it normally is not passed on during the kind of contact that occurs in the school setting. It is more likely to be passed on by close contacts within the family. It is transmitted by the fecal-oral route or by contaminated water or food.

The symptoms of Hepatitis A include any of the following: fever, loss of appetite, nausea, vomiting, fatigue, headache, yellowed skin, light-colored stools, or dark-colored urine. The incubation period can be anywhere from 15-50 days. Obviously, many of these symptoms occur frequently with other ailments, but if your child becomes ill, it would be best to contact your health care provider. If you have any questions, call me, the Fairbanks Regional Public Health Center, or your family physician.

Sincerely,

\_\_\_\_\_  
School Nurse

Phone \_\_\_\_\_

Revised: November 2003

# Hypertension

## BLOOD PRESSURE ASSESSMENT

### **Purpose**

Hypertension is a significant health problem in the United States. Prevalence rates vary by age, race, nutrition, environmental stresses, and certain physical health problems. Hypertension usually begins insidiously, seldom causing symptoms until it is well established. Hypertension may be asymptomatic. Research information from the American Academy of Pediatrics supports the belief that blanket screening of all school children for hypertension is not recommended because of the low yield of cases needing treatment. However, a recommended nursing practice is to screen when necessary.

### NORMAL BLOOD PRESSURE RANGES

Pulse Rate				Blood Pressure					
Normal Range		Average		Age	Range		Average		
130 - 170		120		0 - 6 months	64/30 - 96/62		80/45		
80 - 160		120		6 months - 1yr	60/60 - 118/70		89/60		
80 - 140		120		2 years	74/40 - 124/89		99/60		
80 - 130		110		4 years	79/55 - 110/85		99/60		
80 - 120		92		6 years	80/46 - 118/64		94/62		
75 - 115		85		8 years	89/48 - 121/66		105/60		
70 - 110		78		10 years	94/52 - 128/85		111/66		
70 - 110		74							
Males	Females	Males	Females	12 years	Males	Females	Males	Females	
65-105	70-110	85	90	14 years	92/58-135/86	94/59-132/86	115/72	115/75	
60-100	65-105	80	85	16 years	98/60-142/90	98/62-138/90	120/75	118/76	
60-100	60-100	75	80	18 years	102/60-148/90	100/62-142/90	125/76	122/76	
55-90	55-95	70	75		102/60-148/90	102/62-144/90	128/77	122/77	
					105/62-152/90				

### STANDARDS FOR REFERRAL

**IF EITHER THE SYSTOLIC OR DIASTOLIC READING IS HIGHER THAN THE ABOVE LEVELS, ALLOW STUDENT TO REST FOR 15 MINUTES AND RECHECK. IF THE READINGS ARE STILL HIGHER THAN THE CHART LEVELS, RECHECK ANOTHER DAY.**

Diastolic pressure of 90 mm Hg or above should be confirmed and referred for prompt medical evaluation.

A student with systolic or diastolic pressure above the normal range should have referral made to a parent or guardian. Assistance should be offered if help is needed in obtaining medical follow-up.

Group counseling might be effective if there are a number of students on the secondary level with blood pressure variations.



# FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

520 Fifth Avenue Fairbanks, Alaska 99701-4756 (907) 452-2000



## IMPETIGO

Date \_\_\_\_\_

Dear Parent/Guardian:

\_\_\_\_\_ has a rash I believe is impetigo. The instructions below may help you handle this health problem at home.

- \* **Impetigo is a skin infection caused by a bacteria which often follows sores, insect bites, and other skin rashes.**
- \* **Impetigo can be treated with a medicine such as bacitracin or polysporin which you can buy without a prescription. Read and follow the directions on the medicine.**
- \* **Before you put on the medicine, remove the crusts of the rash by soaking all the sores in warm water for 5 minutes, then washing them with a wash cloth, warm water, and an antiseptic soap.**
- \* **If your child has impetigo in the nose, it may be necessary to put the ointment on a cotton swab and apply it to the sores in the nose.**
- \* Wash your hands after touching the sores.
- \* **Keep you child's towel and washcloth separate. Wash his/her washcloths, towels, bedding, and clothing with hot water and bleach. Dry with high heat or in the sun.**
- \* **Keep your child's fingernails clean and cut short to keep him/her from spreading the rash.**
- \* **Your child can return to school after treatment is started.**
- \* **Cover the sores to prevent the spread to other children.**
- \* **If the rash does not get better, take your child to the doctor.**

\_\_\_\_\_  
School Nurse

\_\_\_\_\_  
Phone

### **Healthy Children Learn Better!**

*Fairbanks North Star Borough School District nurses are doing their part.  
Thank you for doing yours.*





**ALLERGIC REACTION (INDIVIDUAL HEALTH CARE PLAN)**

**CONFIDENTIAL** FOR \_\_\_\_\_ DOB \_\_\_\_\_

Written on \_\_\_\_\_ By \_\_\_\_\_, RN (phone # \_\_\_\_\_)

\_\_\_\_\_ has a health condition you as his/her teacher needs to be aware. The description of this problem, as well as emergency care and individual considerations are stated below. Keep this information available for substitute teachers. Please contact me if you have any questions.

**MEDICAL DIAGNOSIS/CONDITION – Severe Allergic reaction – Use of Epi-Pen**

Anaphylaxis is a life-threatening allergic reaction to a foreign substance. School persons will need to respond immediately. Epinephrine is a medication ordered by a doctor to treat life-threatening allergic reactions. It raises blood pressure and relaxes the airway muscles.

**SIGNS / SYMPTOMS**

\_\_\_\_\_ 1. STUNG BY A BEE (Scrape stinger away when observed; apply ice to sting site.)

\_\_\_\_\_ 2. AFTER INGESTING \_\_\_\_\_

\_\_\_\_\_ 3. AFTER EXPOSURE TO \_\_\_\_\_

- |                                                                                     |                                      |
|-------------------------------------------------------------------------------------|--------------------------------------|
| a. Sneezing, wheezing, or coughing                                                  | k Hoarseness                         |
| b. Difficulty swallowing                                                            | l. Sweating and anxiety              |
| c. Nausea, abdominal pain, vomiting, and diarrhea                                   | m. Rapid weak pulse                  |
| d. Involuntary bowel or bladder emptying                                            | n. Dizziness and/or fainting         |
| e. Burning sensation, especially face or chest                                      | o. Loss of consciousness             |
| f. Blueness around lips, inside lips, eyelids                                       | p. Skin flushing or extreme paleness |
| g. Sense of impending disaster or approaching death                                 |                                      |
| h. Swelling of eyes, lips, face, tongue, throat, or elsewhere                       |                                      |
| i. Itching, with or without hives, raised red rash in any area of body              |                                      |
| j. Shortness of breath or tightness of chest: difficulty in or absence of breathing |                                      |

**ACTION**

1. Delegate calls to:
  - a. Personnel trained to give epinephrine: \_\_\_\_\_
  - b. Nurse, if in building
  - c. 9-1-1 and parent
2. Administer epinephrine:
  - a. Pull off gray safety cap.
  - b. Place black tip of EPI-PEN on outer thigh at right angle to leg. If thigh cannot be used use thickest part of upper arm. DO NOT ATTEMPT INJECTION INTO VEIN OR BUTTOCKS. (It is preferable to remove clothing from site of injection, but may be given through clothing.)
  - c. Press EPI-PEN hard into thigh until auto-injector mechanism functions, and hold in place for several seconds. EPI-PEN may then be removed and discarded. Massage the injection area for 10 seconds.
3. Monitor airway, breathing, and pulse until arrival of 9-1-1.
  - a. Begin CPR for absent breathing.
  - b. Offer reassurance to student, as appropriate.



# FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

520 Fifth Avenue Fairbanks, Alaska 99701-4756 (907) 452-2000



## ARTHRITIS

### Individual Health Care Plan

**Confidential**

FOR \_\_\_\_\_ DOB \_\_\_\_\_

Written on \_\_\_\_\_ By \_\_\_\_\_, RN (phone # \_\_\_\_\_ )

\_\_\_\_\_ has a health condition you as his/her teacher needs to be aware. The description of this problem, as well as emergency care and individual considerations are stated below. Keep this information available for substitute teachers. Please contact me if you have any questions.

**MEDICAL DIAGNOSIS / CONDITION** – *Juvenile Rheumatoid Arthritis*

Juvenile Rheumatoid Arthritis is an inflammatory disorder and is characterized by joint swelling and pain or tenderness. It may also involve organs such as the skin, heart, lungs, liver, spleen and eyes. The affected children may have mild to severe pain.

**SIGNS / SYMPTOMS**

Joints become swollen, tender, and stiff. Most commonly involved joints are the wrists, elbows, knees, ankles, and small joints of the hands and feet. Larger joints may also be affected including those of the cervical spine, hips, and shoulders. Joint pain may not be evident at first, but the child's behavior may clearly suggest joint pain. A child may want to constantly sit in a fixed position, may not walk much, or may refuse to walk at all. Young children are noticeably irritable and listless.

**ACTION**

Student should take his/her medication as prescribed:  
Adaptive P.E. may be needed to maintain joint mobility and muscle strength.

**INDIVIDUAL CONSIDERATION**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Parent(s): \_\_\_\_\_ Home: \_\_\_\_\_ Work: \_\_\_\_\_

\_\_\_\_\_ Home: \_\_\_\_\_ Work: \_\_\_\_\_

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_ Hospital: \_\_\_\_\_

Other Contact Person: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_





# FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

520 Fifth Avenue Fairbanks, Alaska 99701-4756 (907) 452-2000



## ASTHMA Individual Health Care Plan

**Confidential** FOR \_\_\_\_\_ DOB \_\_\_\_\_  
Written on \_\_\_\_\_ by \_\_\_\_\_, RN (phone # \_\_\_\_\_)

\_\_\_\_\_ has a health condition you as his/her teacher needs to be aware. The description of this problem, as well as emergency care and individual considerations are stated below. Keep this information available for substitute teachers. Please contact me if you have any questions.

### MEDICAL DIAGNOSIS / CONDITION – *Asthma*

Asthma is caused by an overactive airway. This may cause episodes of difficult breathing, wheezing and coughing. This overactive response may be started by infection, allergens (e.g., pollens, dust), vigorous exercise, and emotional stress. Treatment includes elimination of the causative agent and medication. Asthma can become life threatening and school persons need to respond immediately.

### SIGNS / SYMPTOMS

- |                                                                                         |                                      |
|-----------------------------------------------------------------------------------------|--------------------------------------|
| 1. Tightness in chest                                                                   | 8. Shortness of breath               |
| 2. Coughing for prolonged periods                                                       | 9. Anxious appearance                |
| 3. Audible wheeze or unusual sounds                                                     | 10. Decreased level of consciousness |
| 4. Need to stand or lean over at waist                                                  |                                      |
| 5. Inability to speak in full sentences without taking a breath or only able to whisper |                                      |
| 6. Bluish discoloration of lips, nails, mucous membranes around eyes/gums               |                                      |
| 7. Coughing that causes choking, a bluish color to lips or persistent vomiting          |                                      |

### ACTION

1. Student should be allowed to use his/her medication. \_\_\_\_\_
2. Stay with student. Monitor for symptoms above.
  - a. When symptoms decrease 15 minutes after taking medications, student may return to class.
  - b. When symptoms increase in severity or there is absent breathing/pulse/decrease level of consciousness, delegate call to 9-1-1, and begin CPR as necessary.
3. Notify parent promptly of incident and action taken.
4. Encourage student to relax by:
  - a. Assuming most comfortable position.
  - b. Doing slow, deep breathing.
  - c. Refocusing on peasant images/thoughts

### INDIVIDUAL CONSIDERATION

\_\_\_\_\_  
\_\_\_\_\_

Parent(s): \_\_\_\_\_ Home: \_\_\_\_\_ Work: \_\_\_\_\_

\_\_\_\_\_ Home: \_\_\_\_\_ Work: \_\_\_\_\_

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_ Hospital: \_\_\_\_\_

Other Contact Person: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_



FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

520 Fifth Avenue Fairbanks, Alaska 99701-4756 (907) 452-2000



Asthma Information and Treatment Letter

Dear Parent/Guardian:

It has been noted on your child's health record that he/she has asthma. It is important to have current health information direction when your child needs help at school. Please complete this form, and return it to school tomorrow so the school nurse may give appropriate instructions to school personnel about your child.

How often does your child have an asthma attack? \_\_\_\_\_

Has hospitalization been needed in the past year for asthma? \_\_\_ No \_\_\_ Yes (when: \_\_\_\_\_)

Is a peak flow meter used? \_\_\_ No \_\_\_ Yes; best flow rate is: \_\_\_\_\_

Asthma is currently being treated by Dr. \_\_\_\_\_ Phone \_\_\_\_\_

CHECK THE CONDITIONS THAT USUALLY BRING ON YOUR CHILD'S ASTHMA ATTACK:

- \_\_\_ Emotional stress \_\_\_ Respiratory infection \_\_\_ Exposure to cold air
\_\_\_ Exercise (describe, e.g., after running) \_\_\_\_\_
\_\_\_ Odors (describe) \_\_\_\_\_
\_\_\_ Allergic reaction (describe: e.g. peanuts, carpets) \_\_\_\_\_
\_\_\_ Other (describe) \_\_\_\_\_

CHECK THE SIGNS THAT ARE USUALLY PRESENT IN THIS STUDENTS ASTHMA ATTACK:

- \_\_\_ Coughing \_\_\_ Wheezing \_\_\_ Shortness of breath \_\_\_ Fear \_\_\_ Bluish color of skin/nails
\_\_\_ Unable to speak sentence without taking a breath, \_\_\_ Other (describe) \_\_\_\_\_

ARE MEDICATIONS NEEDED TO CONTROL THE ALLERGY(IES)? \_\_\_ No \_\_\_ Yes (List below)

Table with 3 columns: \*\*MEDICATIONS, AMOUNT TAKEN, HOW OFTEN AND FOR WHAT SIGNS? and 3 rows of data.

Circle the number of any of these medications to be taken at school.

The USUAL TREATMENT at school for a student having a severe allergic reaction is to:

- Assist the student with the prescribed medication.
Encourage student's relaxation (e.g. slow, deep breathing, sipping warm fluids).
Observe student for inadequate breathing; call 9-1 if inadequate breathing is observed.
Advise parent of symptoms.

If you want additional help given, describe action here: \_\_\_\_\_

If you want the school nurse to be aware of any other comments or special directions, list them here: \_\_\_\_\_

Parent/Guardian Signature Daytime phone number Date

\*\*Tests, medication, and activity restrictions require written direction from the student's doctor.



# FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

520 Fifth Avenue Fairbanks, Alaska 99701-4756 (907) 452-2000

## Cardiac

### INDIVIDUAL HEALTH CARE PLAN

**CONFIDENTIAL** FOR \_\_\_\_\_ DOB \_\_\_\_\_

Written on \_\_\_\_\_ By \_\_\_\_\_, RN (phone # \_\_\_\_\_)

\_\_\_\_\_ has a health condition you as his/her teacher needs to be aware. The description of this problem, as well as emergency care and individual considerations are stated below. Keep this information available for substitute teachers. Please contact me if you have any questions.

#### **MEDICAL DIAGNOSIS / CONDITION** – *Cardiac*

#### **SIGNS / SYMPTOMS**

1. Chest pain
2. Shortness of breath
3. Blue color to lips/mouth area
4. Dizziness

#### **ACTION**

In the event of chest pain, shortness of breath or blue color to lips and mouth area, if student is able, send him/her to the office accompanied by a teacher or responsible student.

#### **CALL:**

1. 911
2. Parent guardian
3. School health services

#### **INDIVIDUAL CONSIDERATION**

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Parent(s): \_\_\_\_\_ Home: \_\_\_\_\_ Work: \_\_\_\_\_

\_\_\_\_\_ Home: \_\_\_\_\_ Work: \_\_\_\_\_

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_ Hospital: \_\_\_\_\_

Other Contact Person: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_



# FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

520 Fifth Avenue Fairbanks, Alaska 99701-4756 (907) 452-2000



## HEMOPHILIA Individual Health Care Plan

### Confidential

FOR \_\_\_\_\_ DOB \_\_\_\_\_

Written on \_\_\_\_\_ By \_\_\_\_\_, RN (phone # \_\_\_\_\_)

\_\_\_\_\_ has a health condition you as his/her teacher needs to be aware. The description of this problem, as well as emergency care and individual considerations are stated below. Keep this information available for substitute teachers. Please contact me if you have any questions.

### **MEDICAL DIAGNOSIS / CONDITION – Hemophilia**

Hemophilia is a disorder that affects the body's ability, when injured, to stop bleeding. This can place a student at risk, if injured, for severe bleeding, either internally or externally. Any injury to head, neck or abdomen is considered an emergency, and school personnel need to take immediate action. Prevention of injury is important; there may be some activity restrictions recommended by a student's doctor.

### **SIGNS/SYMPTOMS THAT MAY ACCOMPANY INTERNAL OR EXTERNAL BLEEDING**

1. Mild bleeding
2. Has had a blow anywhere on body
3. Swelling or bruising of any area of the body
4. Limping or favoring a body part
5. Complains of joint pain

### **ACTION**

1. Immobilize affected part and apply cold compress immediately.
2. Notify immediately, school nurse if in building, otherwise contact parent
3. When unable to reach parent within 30 minutes. Call physician listed below for directions.

### **SIGNS / SYMPTOMS:** *Nosebleed*

### **ACTION**

1. Using gloves, assist student, as needed, in application of cold compress to sides of nose. Student should apply direct pressure to sides of nose, and maintain an upright and forward bending posture.
2. Inform school nurse within 15 minutes, otherwise parent, or physician listed below.

### **SIGNS / SYMPTOMS**

1. Profuse bleeding
2. Injury occurs to head, neck, or abdomen
3. Cold, clammy .moist feeling to skin
4. Anxious appearance
5. Loss of consciousness
6. Loss of consciousness
7. Unusual facial pallor
8. Headaches
9. Blurred vision
10. Confusion
11. Difficulty breathing
12. Sudden vomiting

### **ACTION**

1. Delegate call to 911 and parent
2. Delegate call to School Health Services
3. **DO NOT** attempt to move student if unconscious! (*Exception:* hazardous environment)
4. Apply direct pressure, using gloves/barrier, over site of profuse bleeding.
5. Keep student warm with blankets, as appropriate to environmental temperature



# FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

520 Fifth Avenue Fairbanks, Alaska 99701-4756 (907) 452-2000



## Head Lice

Date \_\_\_\_\_

Classroom \_\_\_\_\_

Parents:

Head lice was found in your child's classroom. As the problem is found, the child is sent home for treatment. Since it is impossible for each child's hair to be examined daily, please check your child at home each day for about two weeks. If lice are found, inform the school nurse or teacher.

### What are head lice?

Head lice are tiny wingless insects that lay eggs (nits) on the hairs, usually about one half to one inch from the scalp. They resemble tiny pussy willows in how they cling to the sides of the hairs. In approximately seven (7) days these eggs hatch, producing more bugs to lay more eggs. The bugs are a brownish color and the eggs are white and resemble dry scalp or dandruff in size and color. The difference is that when you flick the hair with your finger, the egg won't brush off, while dandruff is easily moved. To remove an egg, it is necessary to pull it off between your fingernails. This is because the louse deposits a cement-like substance when the egg is laid, causing it to stay in place. Lice eggs are most frequently found around the nape of the neck and around the area of the ears, but eventually will cover the head if not treated.

### How do you check for head lice?

You can best check for head lice by standing behind the child, tipping the head forward, and dividing the hair with your index finger. Look up and down along the part for the lice eggs. (It is more difficult to see the bugs, because they are more easily camouflaged in dark hair, fewer in number, and move around in the hair.) The lice eggs will be visible about one half to one inch from the scalp, attached to the hairs. Continue to make vertical parts with your index finger, each time inspecting the hairs along the length of the part for nits.

### What is the treatment for head lice?

Treatment consists of everyone in the family shampooing with a head lice shampoo and using a lice comb to remove the nits. This is the first step of treatment. There are products on the market that help loosen the eggs so they are easier to remove, which is the second step of treatment. If even one lice nit remains intact, it will hatch, and the problem will return. Therefore, the removal of the lice eggs is essential! Also, all bedding, coats, clothes, and anything in contact with the person's hair needs to be washed with hot, soapy water. Items such as down clothing need to be sealed in plastic bags for at 2-3 weeks. This allows the eggs to hatch, then die when there is no blood supply for them to survive and reproduce.

### What else can be done?

It is important to let me know promptly if you find head lice on your child, because it may prevent reinfestation in the future if the classroom is checked and one or more students are found to have it. Please emphasize to your children that anyone can get head lice. Clean hair is much more pleasant to check, but certainly will not prevent a person from getting head lice. These creatures are not picky about who they infest. Please instruct your children to bring their own hats, coats, brushes, combs, etc. to school and not to share them with others. It is also helpful to stuff their hats inside a coat sleeve and then put their coats in their own cubby.

\_\_\_\_\_  
Nurse

\_\_\_\_\_  
Phone





# FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

520 Fifth Avenue Fairbanks, Alaska 99701-4756 (907) 452-2000



## LIFTING PROCEDURES INSERVICE Affidavit of Participation

I, \_\_\_\_\_, certify that on \_\_\_\_\_,  
(employee name, please print) (date)

attended an inservice on proper lifting procedures for disabled students. The session covered the following topics:

1. Proper lifting/moving methods for disabled students
2. A review of body mechanics to minimize injury

Signature

\_\_\_\_\_  
Date

Social Security Number



**FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT**

520 Fifth Avenue Fairbanks, Alaska 99701-4756 (907) 452-2000

**ALASKA IMMUNIZATION REQUIREMENTS  
MEDICAL EXEMPTION FORM**

Alaska Immunization Regulation 4AAC 06.055, 4AAC 62.450, and 4 AAC 60.100 require that all children in Alaska public/private schools, certified preschools, and licensed child care facilities be immunized against pertussis (for children less than 7 years of age), diphtheria, tetanus, polio, measles, mumps, rubella, hepatitis A, hepatitis B, varicella (for children in child care facilities and preschools) and Haemophilus influenzae type b (for children less than 5 years of age in child care facilities or preschools), unless he/she is exempt for medical or religious reasons.

If a MEDICAL exemption is requested, complete the required information below and return this form to the school, preschool, or child care facility.

---

Name of Child \_\_\_\_\_ Birthdate \_\_\_\_\_

---

Name of Facility \_\_\_\_\_ Address \_\_\_\_\_ City \_\_\_\_\_ Telephone \_\_\_\_\_

The following section must be completed by an Alaska-licensed Medical Doctor (MD), Doctor of Osteopathy (DO), Advanced Nurse Practitioner (ANP), or Physician-Assistant (PA).

**In my professional opinion, the following immunizations would be injurious to the health of the above named child or members of the child’s family or household.**

This is a Permanent Exemption  Temporary Exemption   
Date exemption expires: \_\_\_\_\_

**Please mark “P” for permanent or “T” for temporary in each vaccine box (ie: P Rubella)**

**Check appropriate antigen(s)**

\_\_\_ ALL vaccines  
\_\_\_ DTP or DtaP \_\_\_ DT or Td \_\_\_ Pertussis \_\_\_ Polio \_\_\_ Measles \_\_\_ Mumps  
\_\_\_ Rubella \_\_\_ Hepatitis A \_\_\_ Hepatitis B \_\_\_ Hib \_\_\_ Varicella (chickenpox)

---

NAME [Please Print] of MD, DO, ANP or PA \_\_\_\_\_ Address \_\_\_\_\_ Telephone \_\_\_\_\_

---

SIGNATURE of MD, DO, ANP or PA \_\_\_\_\_

NOTE: Exemption must be signed only by an Alaska-licensed MD, DO, ANP, or PA.



FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

520 Fifth Avenue Fairbanks, Alaska 99701-4756 (907) 452-2000



**MEDICAL TREATMENT AUTHORIZATION  
FOR SUBSTITUTE PARENT/GUARDIAN**

I give \_\_\_\_\_ permission to write notes, transport,  
(Substitute Parent/Guardian)

and authorize medical treatment at school for \_\_\_\_\_  
(Child)

in my absence.

This is effective from \_\_\_\_\_ to \_\_\_\_\_.  
(Date) (Date)

\_\_\_\_\_  
Parent/Guardian's Signature

Contact Names

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Emergency Numbers

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\* Parents/guardians - Hospitals and clinics may require additional notarized permission for medical treatment.



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FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

520 Fifth Ave. Fairbanks, Alaska 99701-4756 (907) 452-2000

Fairbanks North Star Borough School District



# NO SHOTS - NO SCHOOL!

Check your health records to make sure your children have received all their immunizations.

ALASKA LAW REQUIRES all children be immunized against polio, diphtheria, tetanus, whooping cough, measles, and rubella in order to attend Alaska schools. Verification that a child is appropriately immunized must be medically certified and show the date of each dose of vaccine. Provisions are available for medical or religious exemptions.

If your child needs an immunization, contact your private physician or the Fairbanks Regional Public Health Center.

## DON'T WAIT AND HAVE YOUR CHILD MISS THE FIRST DAY OF SCHOOL

AT THIS AGE	YOUR CHILD SHOULD HAVE RECEIVED	✓
2 months	1 DTP, 1 Polio immunization	
4 months	2 DTP, 2 Polio immunizations	
6 months	3 DTP, 2 Polio immunizations	
15 months	3 DTP immunizations 2 Polio immunizations } (usually given as MMR) 1 Measles immunization 1 Rubella immunization	
18 months	4 DTP immunizations 3 Polio immunizations (If your child has not already received measles or rubella immunization, they are needed.)	
4 to 6 years	2 MMR DTP booster (5th immunization) Polio booster (4th immunization) (If your child has not already received measles and rubella immunization, they are needed.)	
10-year booster	Td booster is due <b>No</b> sooner than 5 years after the initial series is complete. CDC recommends that TB booster be given as early as age 11/12. TB booster is otherwise given 10 years after last DPT.	
	Hepatitis A series of 2 shots 6 months apart	
	Hepatitis B: Series of 3 shots: initial, 1 month, 6 months from 1 <sup>st</sup> vaccination	







# FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

520 Fifth Ave. Fairbanks, Alaska 99701-4756 (907) 452-2000

- 
- ★
- No Symptoms – No symptoms (wheeze, cough, chest tightness, or shortness of breath) even with normal physical activity.
  - Mild Symptoms – Symptoms during physical activity, but not at rest. It does not keep you from sleeping or being active.
  - Moderate Symptoms – Symptoms while at rest; symptoms may keep you from sleeping or being active.
  - Serious Symptoms – Serious symptoms at rest (wheeze may be absent); symptoms cause problems walking or talking, muscles in neck or between ribs are pulled in when breathing.



# FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

520 Fifth Ave. Fairbanks, Alaska 99701-4756 (907) 452-2000

Fairbanks North Star Borough School District



## PHYSICIAN'S AUTHORIZATION FOR HAVING SPECIALIZED NURSING SERVICE PROCEDURE(S) ADMINISTERED

Student's Name \_\_\_\_\_ Date \_\_\_\_\_

Home Address \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_

1. Physical condition for which the standardized procedure is to be performed: \_\_\_\_\_

\_\_\_\_\_

2. Name of standardized procedure: \_\_\_\_\_

Directions (if any): \_\_\_\_\_

3. Precautions, possible untoward reactions, and interventions: \_\_\_\_\_

\_\_\_\_\_

4. Time schedule and/or indication for the procedure: \_\_\_\_\_

\_\_\_\_\_

5. The procedure is to be continued until: \_\_\_\_\_  
Date

\_\_\_\_\_  
Physician's Signature Date

\_\_\_\_\_  
Address Phone

*I hereby request the treatment specified above be performed to the above named student.*

\_\_\_\_\_  
Parent/Guardian's Signature Date

\_\_\_\_\_  
School Nurse Phone

Fax



# FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

520 Fifth Ave. Fairbanks, Alaska 99701-4756 (907) 452-2000



## PINK EYE (CONJUNCTIVITIS)

Date \_\_\_\_\_

Dear Parent/Guardian:

\_\_\_\_\_ has what we believe to be pink eye. Pink eye can be caused by a variety of bacteria, viruses, and other germs, as well as by allergy (pollen) and exposure to chemicals (smoke, cosmetics) or irritants (dust).

The infection spreads from person to person by direct contact, in droplets coughed or sneezed into the air or on hands, towels, and washcloths. The time until illness begins is usually 2 to 7 days after exposure.

The usual signs of pink eye are redness of the white of the eye, tearing (watering of the eyes), or discharge ("matter"). This discharge may be watery or thick with mucus and pus causing the eyelids to stick together. Eyes may burn or itch or may feel as if something is in the eye.

Please consult your child's physician regarding this illness. Your child may return to school when symptoms are gone or when 24 hours of treatment have been completed.

\_\_\_\_\_  
School Nurse

\_\_\_\_\_  
Phone

**Healthy Children Learn Better!**

*Fairbanks North Star Borough School District nurses are doing their part.*

*Thank you for doing yours.*



# FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

520 Fifth Ave. Fairbanks, Alaska 99701-4756 (907) 452-2000

Fairbanks North Star Borough School District



## PSYCHOMOTOR OR PARTIAL SEIZURE

FOR \_\_\_\_\_ DOB \_\_\_\_\_

Written on \_\_\_\_\_ by \_\_\_\_\_, RN Phone \_\_\_\_\_

\_\_\_\_\_ has a health condition you as his/her teacher needs to be aware. The description of this problem, as well as emergency care and individual considerations are stated below. Keep this information available for substitute teachers. Please contact me if you have nay questions.

**Medical Diagnosis / Condition:** Psychomotor or Partial Seizure

A psychomotor or partial seizure is a sudden occurence of reduced level of consciousness and/or localized “jerking” movement of the muscles.

**Signs / Symptoms:**

- |                                                                   |                               |
|-------------------------------------------------------------------|-------------------------------|
| 1. Aura _____                                                     | 7. May run or appear fearful. |
| 2. Blank staring episode followed by chewing activity.            | 8. Post seizure confusion.    |
| 3. May appear dazed and unresponsive.                             | 9. Other _____                |
| 4. May pick at clothing or pick up object.                        |                               |
| 5. Random motor activity with clumsy, nondirected motor activity. |                               |
| 6. May exhibit unprovoked temper tantrums or rages.               |                               |

**Action:**

1. Speak calmly and reassuringly to the student (and others around the student if necessary).
2. Guide student gently away from obvious hazards.
3. Stay with the student until seizure is over.
4. Bring student to health room/office when seizure is over, allow him/her to rest.
5. DO NOT restrain student; seizure must run its course.
6. Be prepared to describe pattern of seizure.
7. Reassure student and classmates.
8. Notify parent/guardian.
9. Record seizure on flow sheet.

**Individual Consideration:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Parent/Guardian \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Physician \_\_\_\_\_ Phone \_\_\_\_\_ Hospital \_\_\_\_\_

Other Contact Person \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_





# FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

520 Fifth Ave. Fairbanks, Alaska 99701-4756 (907) 452-2000



## Allergy Information and Treatment Letter

Dear Parent/Guardian:

It has been noted on your child's health record that he/she has a severe allergy. It is important to have current health information and direction when your child needs help at school. Please complete this form, and return it to school tomorrow so the school nurse may give appropriate instructions to school personnel about your child.

### CHECK ANY ALLERGY(IES) YOUR CHILD HAS:

- a. \_\_\_\_\_ Insect stings (List type):
- b. \_\_\_\_\_ Food (List type):
- c. \_\_\_\_\_ Pollens: Usual time reactions occur: \_\_\_\_\_ spring, \_\_\_\_\_ summer, \_\_\_\_\_ winter, \_\_\_\_\_ fall
- d. \_\_\_\_\_ Dust \_\_\_\_\_ Grass \_\_\_\_\_ Animals (list type)
- e. \_\_\_\_\_ Other (List):

CHECK SIGNS USUALLY PRESENT DURING AN ALLERGY ATTACK. Place letter(s) of the allergies checked above beside the signs listed below:

- \_\_\_\_\_ difficulty breathing \_\_\_\_\_ nausea
- \_\_\_\_\_ difficulty in swallowing \_\_\_\_\_ swelling: how much: \_\_\_\_\_ where? \_\_\_\_\_
- \_\_\_\_\_ loss of consciousness \_\_\_\_\_ flushed or unusually pale skin color
- \_\_\_\_\_ rash \_\_\_\_\_ other (list) \_\_\_\_\_

Has hospitalization been needed in the past year for allergies \_\_\_\_\_ No \_\_\_\_\_ Yes (when: \_\_\_\_\_)

Allergies are currently being treated by Dr. \_\_\_\_\_ Phone: \_\_\_\_\_

List measures needed at school to help prevent a severe allergic reaction:\*\* \_\_\_\_\_

ARE MEDICATIONS NEEDED TO CONTROL THE ALLERGY(IES)? \_\_\_\_\_ No \_\_\_\_\_ Yes (List below)

	**MEDICATIONS	AMOUNT TAKEN	HOW OFTEN AND FOR WHAT SIGNS?
4.	_____	_____	_____
5.	_____	_____	_____
6.	Circle the number of any of these medications to be taken at school.		

The **USUAL TREATMENT** at school for a student having a severe allergic reaction is to:

1. Assist student with the prescribed medication.
2. Observe the student for inadequate breathing; signs of shock; unusual swelling; and when observed, call 911.
3. Report signs to parent

If you want additional help given, describe action here: \_\_\_\_\_

If you want the school nurse to be aware of any other comments or special directions, list them here \_\_\_\_\_

Parent/Guardian Signature

Daytime phone number

Date

\*\*Tests, medication, and activity restrictions require written direction from the student's doctor.



# FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

520 Fifth Ave. Fairbanks, Alaska 99701-4756 (907) 452-2000

Fairbanks North Star Borough School District



## Allergic Reaction

### INDIVIDUAL HEALTH CARE PLAN

**CONFIDENTIAL** FOR \_\_\_\_\_ DOB \_\_\_\_\_

Written on \_\_\_\_\_ By \_\_\_\_\_, RN (phone # \_\_\_\_\_)

\_\_\_\_\_ has a health condition you as his/her teacher needs to be aware. The description of this problem, as well as emergency care and individual considerations are stated below. Keep this information available for substitute teachers. Please contact me if you have any questions.

#### **MEDICAL DIAGNOSIS/CONDITION – Severe Allergic reaction – Use of Epi-Pen**

Anaphylaxis is a life-threatening allergic reaction to a foreign substance. School persons will need to respond immediately. Epinephrine is a medication ordered by a doctor to treat life-threatening allergic reactions. It raises blood pressure and relaxes the airway muscles.

#### SIGNS / SYMPTOMS

- \_\_\_\_\_ 1. STUNG BY A BEE (Scrape stinger away when observed; apply ice to sting site.)  
 \_\_\_\_\_ 2. AFTER INGESTING \_\_\_\_\_  
 \_\_\_\_\_ 3. AFTER EXPOSURE TO \_\_\_\_\_

- |                                                                                     |                                      |
|-------------------------------------------------------------------------------------|--------------------------------------|
| k. Sneezing, wheezing, or coughing                                                  | k. Hoarseness                        |
| l. Difficulty swallowing                                                            | l. Sweating and anxiety              |
| m. Nausea, abdominal pain, vomiting, and diarrhea                                   | m. Rapid weak pulse                  |
| n. Involuntary bowel or bladder emptying                                            | n. Dizziness and/or fainting         |
| o. Burning sensation, especially face or chest                                      | o. Loss of consciousness             |
| p. Blueness around lips, inside lips, eyelids                                       | p. Skin flushing or extreme paleness |
| q. Sense of impending disaster or approaching death                                 |                                      |
| r. Swelling of eyes, lips, face, tongue, throat, or elsewhere                       |                                      |
| s. Itching, with or without hives, raised red rash in any area of body              |                                      |
| t. Shortness of breath or tightness of chest: difficulty in or absence of breathing |                                      |

#### ACTION

3. Delegate calls to:
- Personnel trained to give epinephrine: \_\_\_\_\_
  - Nurse, if in building
  - 9-1-1 and parent
4. Administer epinephrine:
- Pull off gray safety cap.
  - Place black tip of EPI-PEN on outer thigh at right angle to leg. If thigh cannot be used use thickest part of upper arm. **DO NOT ATTEMPT INJECTION INTO VEIN OR BUTTOCKS.** (It is preferable to remove clothing from site of injection, but may be given through clothing.)
  - Press EPI-PEN hard into thigh until auto-injector mechanism functions, and hold in place for several seconds. EPI-PEN may then be removed and discarded. Massage the injection area for 10 seconds.
3. Monitor airway, breathing, and pulse until arrival of 9-1-1.
- Begin CPR for absent breathing.
  - Offer reassurance to student, as appropriate.



FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

520 Fifth Ave. Fairbanks, Alaska 99701-4756 (907) 452-2000



# Allergies

## INDIVIDUAL HEALTH CARE PLAN

**CONFIDENTIAL** FOR \_\_\_\_\_ DOB \_\_\_\_\_

Written on \_\_\_\_\_ By \_\_\_\_\_, RN (phone # \_\_\_\_\_)

\_\_\_\_\_ has a health condition you as his/her teacher needs to be aware. The description of this problem, as well as emergency care and individual considerations are stated below. Keep this information available for substitute teachers. Please contact me if you have any questions.

**MEDICAL DIAGNOSIS/CONDITION**

Environmental and/or grass allergies

SIGNS / SYMPTOMS

1. Itchy watery eyes
2. Excessive coughing or sneezing
3. Wheezing
4. Pallor
5. Difficulty breathing

ACTION

1. Eliminate and/or reduce exposure to the triggers (e.g. grass, chalk dust, animal dander).
2. Keep students who have these types of allergies indoors when it is excessively windy and/or the school yard grass is being mowed.

**INDIVIDUAL CONSIDERATION**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Parent(s): \_\_\_\_\_ Home: \_\_\_\_\_ Work: \_\_\_\_\_

\_\_\_\_\_ Home: \_\_\_\_\_ Work: \_\_\_\_\_

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_ Hospital: \_\_\_\_\_

Other Contact Person: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_



# FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

520 Fifth Ave. Fairbanks, Alaska 99701-4756 (907) 452-2000

Fairbanks North Star Borough School District



Health Services  
Individualized Health Care Plan  
(Asthma)

STUDENT	DATE	DOB	
PHYSICIAN	PHONE	TEACHER	
	PHONE		
PRIMARY DIAGNOSIS - ASTHMA			
SECONDARY DIAGNOSIS			
ALLERGIES		DIET	
PAST MEDICAL HX		MOBILITY	
CURRENT MEDS		SPECIAL EQUIPMENT	
SIGNATURE (Parent/Guardian)		SIGNATURE (Nurse)	

DATE	HEALTH CONCERN/ NURSING DIAGNOSIS	STUDENT GOALS	INTERVENTIONS AND RESPONSIBLE PERSON	EVALUATION AND TIMELINE
	Ineffective airway related to bronchospasm.	Clear Airway.	Nurse will: I. EVALUATE AIRWAY 1. OBSERVE Color Respiratory rate Cough Nasal flaring Audible wheeze Retractions 2. AUSCULTATE lungs 3. OBTAIN peak flow reading and compare with baseline in health record. II. ADMINISTER PRESCRIBED MEDS 1. OBSERVE for proper use of medication. 2. OBTAIN peak flow reading and compare with premedication reading. III. NOTIFY PHYSICIAN/PARENT (PRN) IV. PREPARE IECP	
	Increased pulmonary secretions.	Clear airway.  Student will demonstrate adequate understanding of the need for adequate hydration.	Nurse will: I. OBSERVE FOR PRODUCTIVE COUGH 1. ENCOURAGE clearing of airway. 2. OFFER clear fluids. 3. ADVISE increase daily fluid intake to liquidity secretions (more with exercise or hot or dry weather) Nurse will: 1. ASSIST student to relax in upright position of comfort. 2. BE assuring and calming. 3. ENCOURAGE slow, steady breathing. 4. EVALUATE any pattern to flare-up, e.g., test times, field trips. 5. SCHEDULE time to instruct student in relaxation and breathing techniques.	
	Anxiety related to breathlessness and fear of recurrence.	Reduced anxiety during flare-ups. Student will learn relationship between anxiety and asthma symptoms.	Nurse will: 1. SCHEDULE time to instruct student about asthma. 2. Proper use of inhalers and the correct order to use them, e.g., bronchodilator first and steroid second. 3. Side effects of medications. 4. Caution regarding the use of over-the-counter medication. 5. Use of inhalers at school. 6. Over use of inhalers. If applicable, adequate preparation before sports.	
	Knowledge deficits: 1. Diagnosis 2. Environmental hazards - smoking, allergies, weather 3. Pharmacologic therapy	Student will describe and demonstrate an understanding of the effects of asthma on the respiratory system. Student will become aware of exposure to hazards and the impact on the respiratory system. Student will demonstrate an understanding of medications prescribed by his/her physician.		



FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

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Fairbanks North Star Borough School District



# Asthma Information and Treatment Letter

Dear Parent/Guardian:

It has been noted on your child's health record that he/she has asthma. It is important to have current health information direction when your child needs help at school. Please complete this form, and return it to school tomorrow so the school nurse may give appropriate instructions to school personnel about your child.

How often does your child have an asthma attack? \_\_\_\_\_

Has hospitalization been needed in the past year for asthma? \_\_\_\_ No \_\_\_\_ Yes (when: \_\_\_\_\_)

Is a peak flow meter used? \_\_\_\_ No \_\_\_\_ Yes; best flow rate is: \_\_\_\_\_

Asthma is currently being treated by Dr. \_\_\_\_\_ Phone \_\_\_\_\_

**CHECK THE CONDITIONS THAT USUALLY BRING ON YOUR CHILD'S ASTHMA ATTACK:**

- \_\_\_\_ Emotional stress \_\_\_\_ Respiratory infection \_\_\_\_ Exposure to cold air
- \_\_\_\_ Exercise (describe, e.g., after running) \_\_\_\_\_
- \_\_\_\_ Odors (describe) \_\_\_\_\_
- \_\_\_\_ Allergic reaction (describe: e.g. peanuts, carpets) \_\_\_\_\_
- \_\_\_\_ Other (describe) \_\_\_\_\_

**CHECK THE SIGNS THAT ARE USUALLY PRESENT IN THIS STUDENTS ASTHMA ATTACK:**

- \_\_\_\_ Coughing \_\_\_\_ Wheezing \_\_\_\_ Shortness of breath \_\_\_\_ Fear \_\_\_\_ Bluish color of skin/nails
- \_\_\_\_ Unable to speak sentence without taking a breath, \_\_\_\_ Other (describe) \_\_\_\_\_

ARE MEDICATIONS NEEDED TO CONTROL THE ALLERGY(IES)? \_\_\_\_ No \_\_\_\_ Yes (List below)

	**MEDICATIONS	AMOUNT TAKEN	HOW OFTEN AND FOR WHAT SIGNS?
7.	_____	_____	_____
8.	_____	_____	_____

9. Circle the number of any of these medications to be taken at school.

The **USUAL TREATMENT** at school for a student having a severe allergic reaction is to:

- Assist the student with the prescribed medication.
- Encourage student's relaxation (e.g. slow, deep breathing, sipping warm fluids).
- Observe student for inadequate breathing; call 9-1 if inadequate breathing is observed.
- Advise parent of symptoms.

If you want additional help given, describe action here: \_\_\_\_\_

If you want the school nurse to be aware of any other comments or special directions, list them here: \_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Daytime phone number

\_\_\_\_\_  
Date

\*\*Tests, medication, and activity restrictions require written direction from the student's doctor.

# FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

520 Fifth Ave. Fairbanks, Alaska 99701-4756 (907) 452-2000



Fairbanks North Star Borough School District

Name: \_\_\_\_\_

## ASTHMA DIARY PEAK FLOW

For adults, teens & children  
five years of age and over

Signs	Medicines*	Peak Flow Rate					Date	Triggers, Comments
		Green Zone	Yellow Zone	High Yellow Zone	Low Yellow Zone	Red Zone		
Wheezes	Inhaled steroid	100%						
Cough	Cromolyn or nedocromil	90%						
Activity	Adrenaline-like medicine	80%						
Sleep	Oral steroid	70%						
	Theophylline	65%						
		60%						
		50%						

\* Medicines: • Inhaled steroid (Aerobid, Azmacort, Beclovent, Flovent, Pulmicort, Vancort) • Cromolyn (Intal) • Mometasone (Nasonex) • Adrenaline-like: albuterol (Proventil, Ventolin), metaproterenol (Aluproc), pirbuterol (Maxair), terbutaline (Brethine or Bricanyl) • Oral steroid (prednisone, prednisolone, methylprednisolone) • Theophylline (Slo-bid, ephedrine, Uni-Dur and Uniphyll tablets) • Ipratropium (Atrovent). Your doctor may prescribe others.

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See back for instructions. Please bring to each visit.

### Signs

- ◆ Wheezes:
  - None ..... 0
  - End of exhale ..... 1
  - Through/just exhale ..... 2
  - Inhale and exhale ..... 3
- ◆ Cough in past 5 minutes:
  - None ..... 0
  - Less than one per minute ..... 1
  - One to four per minute ..... 2
  - More than four per minute ..... 3
- ◆ Activity:
  - Fully active ..... 0
  - Can run short distance ..... 1
  - Can walk only ..... 2
  - Missed work or school or stayed indoors ..... 3
- ◆ Sleep:
  - Fine ..... 0
  - Slight wheeze or cough ..... 1
  - Awake 2-3 times because of wheeze or cough ..... 2
  - Awaker most of the night ..... 3

Order books & diaries from Pedipress 800-611-6081.

- Children with Asthma: A Manual for Parents
- Our Minute Asthma: What You Need to Know
- El asma en tu idioma
- Winning Over Asthma
- Asthma Peak Flow Diary
- Asthma Signe Diary
- Asthma Charts & Forms for the Physician's Office



# FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

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Fairbanks North Star Borough School District



Name \_\_\_\_\_  
 \_\_\_\_\_ predicted peak flow  
 \_\_\_\_\_ personal best peak flow

\_\_\_\_\_ green (OK) zone  
 \_\_\_\_\_ yellow (caution) zone  
 \_\_\_\_\_ red (danger) zone

DATE												
MEDS												
TIME	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
READING												
500												
400												
300												
200												
100												
0												
	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
No Symptoms												
Mild Symptoms												
Moderate Symptoms												
Serious Symptoms												
Meds Used to Stop												
Urgent Visit to MD/ER												

- No Symptoms - No symptoms (wheeze, cough, chest tightness, or shortness of breath) even with normal physical activity.
- Mild Symptoms - Symptoms during physical activity, but not at rest. It does not keep you from sleeping or being active.
- Moderate Symptoms - Symptoms while at rest; symptoms may keep you from sleeping or being active.
- Serious Symptoms - Serious symptoms at rest (wheeze may be absent); symptoms cause problems walking or talking, muscles in neck or between ribs are pulled in when breathing.





# FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

520 Fifth Ave. Fairbanks, Alaska 99701-4756 (907) 452-2000



**ASTHMA ASSESS DAILY RECORD CHART**

Date Time	Name																									
850																										
800																										
750																										
700																										
650																										
600																										
550																										
500																										
450																										
400																										
350																										
300																										
250																										
200																										
150																										
100																										

Notes:

ASSESS ® Daily Record Chart



# FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

520 Fifth Ave. Fairbanks, Alaska 99701-4756 (907) 452-2000

## STUDENT BEHAVIOR OBSERVATION

SCHOOL PROGRESS REPORT						DATE
STUDENT			SCHOOL			
TEACHER			GRADE			
Traits compared to student's classmates.			PERFORMANCE	Traits of the student which you note to be changing (if this is a follow-up report).		
AVERAGE OR BETTER	BELOW AVERAGE	DEFINITE PROBLEM		WORSE	SAME	IMPROVED
			ATTENTION SPAN			
			TASK COMPLETION			
			EMOTIONAL MATURITY			
			PEER ACCEPTANCE			
			FOLLOWS DIRECTIONS			
			SELF-ESTEEM			
			READING			
			HANDWRITING			
			ARITHMETIC			
			SPELLING			
			COORDINATION			
			EFFORT			
			USES TIME WISELY			
			TOLERANCE TO OTHERS			
Traits compared to student's classmates.			PERFORMANCE	Traits of the student which you note to be changing (if this is a follow-up report).		
NOT A PROBLEM	GREATER THAN AVERAGE FOR AGE & CLASS	EXCESSIVE		WORSE	SAME	IMPROVED
			BEHAVIOR PROBLEM			
			LOSES INTEREST EASILY			
			IS DISTRACTABLE			
			DISTRACTS OTHERS			
			AGGRESSIVENESS			
			FRUSTRATION LEVEL			
			IMPULSIVENESS			
			DISTURBS CLASS			
			ACTIVITY LEVEL			
			TEMPER OUTBURST			
			IRRITABILITY			
			SENSITIVITY			
			DAYDREAMING			
			LETHARGY			
			ANXIETY LEVEL			





# FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

520 Fifth Ave. Fairbanks, Alaska 99701-4756 (907) 452-2000



## Dental Referral

Date \_\_\_\_\_ School \_\_\_\_\_

Student \_\_\_\_\_ DOB \_\_\_\_\_ Grade \_\_\_\_\_

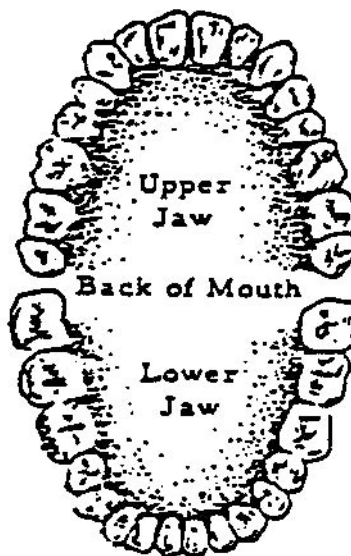
School Address \_\_\_\_\_ Phone \_\_\_\_\_ FAX \_\_\_\_\_

Dear Parent/Guardian:

Your child recently had a dental screening and assessment as part of the health appraisal done by the school nurse. Checked item(s) needs further examination or treatment. Please make an appointment as soon as possible. Return the signed form to the school nurse's office (address above).

- Cavities
- Malocclusion
- Routine Dental Exam
- Other \_\_\_\_\_

\_\_\_\_\_  
Nurse's Signature



### DENTIST REPORT

Evaluation:

Dentist's Signature \_\_\_\_\_ Date \_\_\_\_\_

*Please return signed form to the nurse's office (address above).  
Information will remain on file in the student's health folder.*



# FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

520 Fifth Ave. Fairbanks, Alaska 99701-4756 (907) 452-2000



## Hearing Referral

Date \_\_\_\_\_ School \_\_\_\_\_  
 Student \_\_\_\_\_ DOB \_\_\_\_\_ Grade \_\_\_\_\_  
 School Address \_\_\_\_\_ Phone \_\_\_\_\_ FAX \_\_\_\_\_

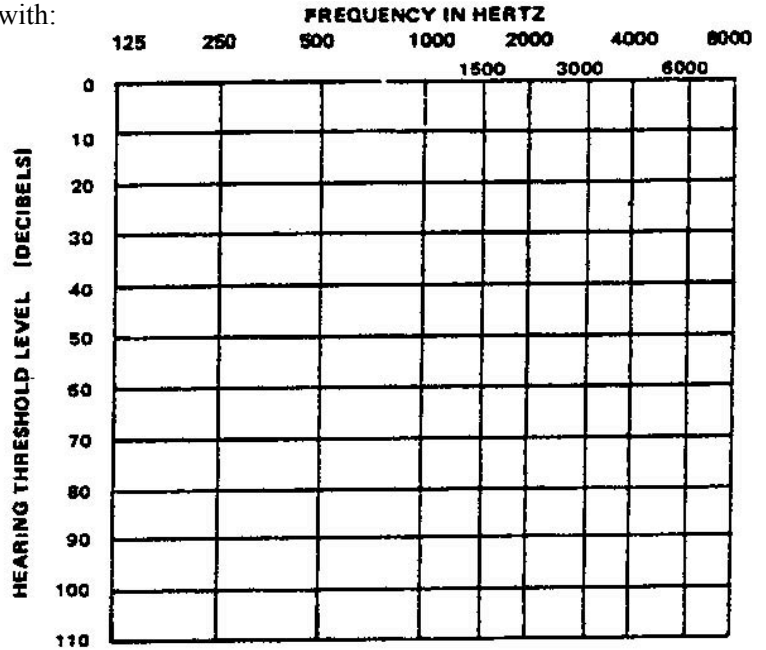
Dear Parent/Guardian:

Your child recently had a hearing screening and assessment as part of the health appraisal done by the school nurse. The following was noted: \_\_\_\_\_

Please make an appointment for further evaluation with:

- your family doctor
- Military ENT Clinic
- Ear, Nose, and Throat Clinic

\_\_\_\_\_  
Nurse's Signature



Left ear X (blue) X -- X  
 Right ear O (red) O -- O

-----  
**EXAMINER'S REPORT**

Results/Recommendations:

Signature \_\_\_\_\_ Title \_\_\_\_\_  
 Date \_\_\_\_\_

*Please return signed form to the nurse's office (address above).  
 Information will remain on file in the student's health folder.*



# FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

520 Fifth Ave. Fairbanks, Alaska 99701-4756 (907) 452-2000

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★

## Staff Medical History

Name \_\_\_\_\_ Date \_\_\_\_\_

Date of Birth \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

### **IN CASE OF EMERGENCY CALL:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Preferred Emergency Facility:     Bassett Army Hospital     Fairbanks Memorial Hospital

Please give any information about any health problems or physical disabilities you may have. List involvement of eyes, ears, heart, etc.

Physician \_\_\_\_\_ Phone \_\_\_\_\_

Medication(s) at the Present Time \_\_\_\_\_

\_\_\_\_\_

Immunizations: Date of Last Diphtheria/Tetanus Booster \_\_\_\_\_

Allergies \_\_\_\_\_

**Staff** – This form is not mandatory, but you are encouraged to complete it and leave it on file in the nurse's office in case of emergency.



# FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

520 Fifth Ave. Fairbanks, Alaska 99701-4756 (907) 452-2000



## Release of Information For Medical History

The following information on the health and developmental history of your child may be very valuable in determining the type and direction of educational services that will best serve your child. You may feel some of these questions are of a personal nature and may choose not to answer them. The information contained in this document will be shared with school personnel involved in the educational services for your child, i.e., classroom teacher, special education teacher, principal.

### **RELEASE OF INFORMATION:**

I give permission for the school to release this information to my physician and for my physician to release the results of any relevant evaluations to the school.

Parent/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

Physician \_\_\_\_\_

School Interviewer \_\_\_\_\_

# Immunization Referral/Update

## IMPORTANT NOTICE REQUIRING A RESPONSE

Dear Parent/Guardian:

Date \_\_\_\_\_

A recent review of immunization records shows \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
(child) (grade)  
is not adequately immunized as required by state immunization regulations. Please obtain dates of the immunizations or have your child vaccinated. Provide a record to the school by \_\_\_\_\_.

**NOTE:** *The dates for each dose must be documented on an official record or a written statement signed by your physician or health care provider.*

	1	2	3	4	5	10 Yr. Booster
DTP/DT/Td						
POLIO						
MMR						
HEPATITIS A						
HEPATITIS B						
OTHER						

*The boxes checked below indicate information missing from school records.*

### DTP and/or POLIO:

The DTP and/or Polio boxes are checked because dates or doses are missing.

### HEPATITIS A and/or B:

The Hepatitis A and/or Hepatitis B boxes are checked because dates or doses are missing.

### MMR:

There is no record of 2 MMR vaccinations.

The vaccine was received before the first birthday and therefore the child must be revaccinated, or there is insufficient information on the record to determine if the vaccine was received on or after the first birthday.

Record shows disease history. This cannot be accepted without a laboratory (titer) result. Vaccination is required.

If your physician feels revaccination is medically contraindicated (not appropriate), a statement signed by the physician must be given to the school.

Take this letter with you when you visit your physician, health department, or clinic. Immunizations may be obtained at the Fairbanks Public Health Center (452-1776) or your family physician.

If you have questions or need additional information, call me at \_\_\_\_\_.

\_\_\_\_\_  
School Nurse

\_\_\_\_\_  
FAX

**A RESPONSE TO THIS LETTER IS REQUIRED.**





# FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

520 Fifth Ave. Fairbanks, Alaska 99701-4756 (907) 452-2000



## Tetanus/Diphtheria Booster

Date \_\_\_\_\_

Dear Parent/Guardian:

The last recorded tetanus/diphtheria (Td) immunization for \_\_\_\_\_ was \_\_\_\_\_ . Ten years have elapsed since the last one. Your child is now due for a Td booster. If your child had one recently, please send or FAX verification so the date can be entered in the school health record.

If not, immunizations may be obtained at the Chief Andrew Isaac Health Center, Fairbanks Regional Public Health Center, or at your medical care provider.

Military dependents may get a Td booster at Bassett Army Community Hospital or Eielson Air Force Base Clinic.

Call me at \_\_\_\_\_ if you have any questions.

\_\_\_\_\_  
School Nurse

\_\_\_\_\_  
FAX



# FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

520 Fifth Ave. Fairbanks, Alaska 99701-4756 (907) 452-2000



## Individualized Emergency Care Plan

Student \_\_\_\_\_ Sex \_\_\_\_\_ DOB \_\_\_\_\_ Date \_\_\_\_\_

Primary diagnosis, concern, or pertinent background.

Allergies? No \_\_\_\_\_ Yes \_\_\_\_\_ Please specify \_\_\_\_\_

Parent/Guardian \_\_\_\_\_

Work Phone \_\_\_\_\_ Home Phone \_\_\_\_\_ Cellular Phone \_\_\_\_\_

Address \_\_\_\_\_

Primary Health Care Physician \_\_\_\_\_ Phone \_\_\_\_\_

May we contact your primary care physician in the event of a concern or question? Yes \_\_\_\_\_ No \_\_\_\_\_

List other physicians, specialists, therapists, or clinics consulted, the reason for consultation, and the most recent exam date. May we contact them in the event of a concern or question? Yes \_\_\_\_\_ No \_\_\_\_\_

<i>Name</i>	<i>Reason</i>	<i>Last Exam</i>

What medication is your child currently taking and for what reason?

<i>Medication</i>	<i>How Often</i>	<i>Reason</i>	<i>Any Side Effects Noticed</i>	<i>Prescribing Physician</i>





FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

FORMS

520 Fifth Ave. Fairbanks, Alaska 99701-4756 (907) 452-2000

Fairbanks North Star Borough School District  
Health Services

INDIVIDUALIZED HEALTH CARE PLAN

STUDENT	DATE	DOB
PHYSICIAN	TEACHER	
PHONE		
PHYSICIAN	PHONE	
PRIMARY DIAGNOSIS		
SECONDARY DIAGNOSIS		
ALLERGIES	DIET	
PAST MEDICAL HX	MOBILITY	
CURRENT MEDS	SPECIAL EQUIPMENT	
SIGNATURE (Parent/Guardian)	SIGNATURE (Nurse)	
Date	Health Concern / Nursing Diagnosis	Student Goal
	Intervention and Responsible Person	Evaluation and Timeline

Student

Date	Health Concern / Nursing Diagnosis	Student Goal	Intervention and Responsible Person	Evaluation and Timelime



FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

FORMS

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★  
**Prehospital Report**

<b>Patient Information</b>										Date _____
Patient Name: _____					Parent/Guardian Name (if a minor): _____					
Mailing Address: _____ (City) (State) (Zip)					Patient S.S.# or Active Duty Person's S.S.# _____					
Sex: _____					DOB: _____			Age: _____		
Phone: _____			Scene Location: _____			Transport to: _____				
TIME	DISPATCH	OUT	ON SCENE	LEAVE SCENE	AT HOSPITAL	IN SERVICE	AT STATION	PERSONAL ITEMS: _____		
ODOM								SCHOOL EQUIPMENT: _____		
Severity of Distress: none <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe <input type="checkbox"/>										Incident: Medical / Trauma _____
at Patient Contact: _____										Allergies: _____ Doctor: _____
Medications: _____										
TIME	LOC/GCS	PULSE	B/P	RESP	O2 SAT	OXYGEN	PUPILS	SKINS	LUNGS	MEDICATIONS/PROCEDURES
IV #1 Site: _____		Ga: _____		Fluid: _____		IV #2 Site: _____		Ga: _____		Fluid: _____
									Total Amt: _____	cc
Pre-Ambulance Care:										
CC: _____										
Hx: _____										
Sit: _____										
PE: _____										
Imp: _____										
Plan: _____										

School Nurse: \_\_\_\_\_

**Medical and Liability Release Form**

I hereby release the Fairbanks North Star Borough and \_\_\_\_\_ Mobile Intensive Care and/or Ambulance Service, their employees and administrative officers, from any liability or medical claims resulting from my refusal of Emergency Care and/or Transportation to the nearest Recommended Medical Facility. I further understand that I have been directed to contact my Personal Physician as to my present condition.

Patient's Signature	Date	Responsible Relative's Signature	Date
Medic's Signature	Date	Witness	Date





# Medical Treatment Authorization for Substitute Parent/Guardian

I give \_\_\_\_\_ permission to write notes, transport,  
(Substitute Parent/Guardian)  
and authorize medical treatment at school for \_\_\_\_\_  
(Child)  
in my absence.

This is effective from \_\_\_\_\_ to \_\_\_\_\_  
(Date) (Date)

\_\_\_\_\_  
Parent/Guardian's Signature

Contact Names  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Emergency Numbers  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\* Parents/guardians- Hospitals and clinics may require additional notarized permission for medical treatment.





## FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

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## Request for Administration of Medication

If this form is properly completed and returned to the school nurse/principal, the Fairbanks North Star Borough School District may assist parents when their child's physician has prescribed medication for the child. The medication will only be given if it is delivered to the principal or his/her designee in the original bottle marked with the student's name, dosage, time of administration, physician, pharmacy, and date of purchase.

Student \_\_\_\_\_ Birth Date \_\_\_\_\_  
School \_\_\_\_\_ Grade \_\_\_\_\_

### ***PHYSICIAN SECTION: (TO BE FILLED OUT BY THE PHYSICIAN)***

Medication \_\_\_\_\_ Diagnosis \_\_\_\_\_

Dosage and Time of Administration \_\_\_\_\_

Discontinue Medication On \_\_\_\_\_

For Inhalers, Students May Keep this on Their Person: Yes \_\_\_\_\_ No \_\_\_\_\_

#### **POSSIBLE SIDE EFFECTS**

- |                                        |                                           |
|----------------------------------------|-------------------------------------------|
| <input type="checkbox"/> aggression    | <input type="checkbox"/> loss of appetite |
| <input type="checkbox"/> edginess      | <input type="checkbox"/> sleep problems   |
| <input type="checkbox"/> headache      | <input type="checkbox"/> stomachache      |
| <input type="checkbox"/> jaw clenching | <input type="checkbox"/> weight loss      |

Other Medications Student is Taking \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

Physician's Phone \_\_\_\_\_

### **PARENT/GUARDIAN STATEMENT**

As the parent/guardian (*circle one*) of the above-named student, I do hereby request the school district give medication to the above-named student. I understand that the school district is not legally obligated to administer medication to the student, and in the absence of the school nurse, other school personnel may administer the medication. I agree not to institute suit against the school district for administration or non-administration of the medication, to defend and hold the school district harmless from any liability resulting from the administration or non-administration of the medication, and to defend and indemnify the school and its employees from any liability arising out of this agreement. *I will notify the school nurse/principal immediately if the medication is changed.* I give my permission for the exchange/release of medical information regarding the above student/treatment.

\_\_\_\_\_  
Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

### **SCHOOL ACKNOWLEDGMENT**

School Nurse \_\_\_\_\_ Date \_\_\_\_\_

Pharmacy \_\_\_\_\_ Rx Number \_\_\_\_\_ Date \_\_\_\_\_

Physician's Name (please print) \_\_\_\_\_



# FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

520 Fifth Ave. Fairbanks, Alaska 99701-4756 (907) 452-2000



## Staff Authorization to Dispense Medication

### *FIELD TRIPS*

I knowingly give permission for the Fairbanks North Star Borough School District designated staff member to dispense medication to my son/daughter on the days the student is out of the building.

Child \_\_\_\_\_ Grade \_\_\_\_\_

Staff Member \_\_\_\_\_

Medication \_\_\_\_\_

Dosage and Time of Administration \_\_\_\_\_

### **STATEMENT OF PARENT/GUARDIAN**

As parent/guardian (circle one) of the above-named student, I do hereby request the Fairbanks North Star Borough School District give medication to the above-named student. I understand that the school district is not legally obligated to administer medication to the student, and in the absence of the school nurse, other school personnel will administer the medication. I agree not to institute suit against the school district for administration or non-administration of the medication, to defend and hold the school district harmless from any liability resulting from the administration or non-administration of the medication, and to defend and indemnify the school district and its employees from any liability arising out of this

Parent/Guardian Signature \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Contact Person \_\_\_\_\_ Emergency Phone \_\_\_\_\_

Please send medication in the original prescription container and send amount needed for the duration of the field trip.



# FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

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## Medication Update for Next School Year

Date \_\_\_\_\_

Dear Parent/Guardian:

Enclosed is your child's medication and a new medication form that needs to be completed by your physician if your child is to continue on medication in the fall.

**REMEMBER:** All medication must be in a properly marked container be dispensed by the school nurse or authorized staff and must be accompanied by the physician's authorization.

Thank you.

\_\_\_\_\_  
Nurse

\_\_\_\_\_  
School

\_\_\_\_\_  
Phone



## FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

520 Fifth Ave. Fairbanks, Alaska 99701-4756 (907) 452-2000



# Pacemaker

## INDIVIDUAL HEALTH CARE PLAN

**CONFIDENTIAL** FOR \_\_\_\_\_ DOB \_\_\_\_\_

Written \_\_\_\_\_ By \_\_\_\_\_, RN (phone # \_\_\_\_\_)

\_\_\_\_\_ has a health condition you as his/her teacher needs to be aware. The description of this problem, as well as emergency care and individual considerations are stated below. Keep this information available for substitute teachers. Please contact me if you have any questions.

### **MEDICAL DIAGNOSIS / CONDITION** – Pacemaker

A pacemaker is an electrical apparatus used in maintaining normal heart rate when the heart is unable to do so. Pacemakers can be permanent or temporary. Some students may require special activity directions due to the heart problem. Should the student's pacemaker not work properly, the student will need immediate medical assessment

### **SIGNS / SYMPTOMS**

- |                        |                              |
|------------------------|------------------------------|
| 1. Lethargy            | 5. Fatigue                   |
| 2. Dizziness           | 6. Hiccoughs                 |
| 3. Shortness of breath | 7. Unusually pale skin color |
| 4. Pulse < _____       |                              |

### **ACTION**

1. Stay with student
2. Delegate call to school nurse immediately in building; otherwise parent to pick student up.

### **SIGNS / SYMPTOMS**

- |                                                                                                      |                               |
|------------------------------------------------------------------------------------------------------|-------------------------------|
| 1. Pulse < _____                                                                                     | 4. Exhibits trouble breathing |
| 2. Lips, skin, nail beds are bluish in color                                                         | 5. Chest pain                 |
| 3. Symptoms persist and parent/family member does not arrive to take student home within 30 minutes. |                               |

### **ACTION**

1. Stay with student
2. Delegate calls to 9-1-1 and parent
3. Delegate someone to locate and request 1st responders to report to the student's location.

### **SIGN / SYMPTOMS:**

Absent breathing/pulse

### **ACTION**

1. Stan CPR
2. Delegate call to 9-1-1 and parent

### **SIGNS / SYMPTOMS:**

Nausea/vomiting  
Jaundice  
Temperature above 100.5 degrees Fahrenheit

### **ACTION**



# FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

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Notify school nurse promptly , if in building; otherwise parent.



# FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

520 Fifth Ave. Fairbanks, Alaska 99701-4756 (907) 452-2000



## Parent/Teacher Conference

### *MEDICAL REFERRAL UPDATE*

Date \_\_\_\_\_

Dear Teachers:

\_\_\_\_\_ was referred for a(n) \_\_\_\_\_ exam.

Please check with the parent/guardian at conference time to see what follow-up has been done. The parent/guardian may come to my office if necessary.

Nurse \_\_\_\_\_

Follow-up \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

School \_\_\_\_\_

**HALL PASS**  
**Fairbanks North Star Borough School District**

Student \_\_\_\_\_ Date \_\_\_\_\_

Issued By \_\_\_\_\_ Time \_\_\_\_\_

Destination \_\_\_\_\_ Time \_\_\_\_\_

Time Returned \_\_\_\_\_

*Students: It is against school rules to forge, alter, or possess blank passes.*

-----

School \_\_\_\_\_

**HALL PASS**  
**Fairbanks North Star Borough School District**

Student \_\_\_\_\_ Date \_\_\_\_\_

Issued By \_\_\_\_\_ Time \_\_\_\_\_

Destination \_\_\_\_\_ Time \_\_\_\_\_

Time Returned \_\_\_\_\_

*Students: It is against school rules to forge, alter, or possess blank passes.*

-----

School \_\_\_\_\_

**HALL PASS**  
**Fairbanks North Star Borough School District**

Student \_\_\_\_\_ Date \_\_\_\_\_

Issued By \_\_\_\_\_ Time \_\_\_\_\_

Destination \_\_\_\_\_ Time \_\_\_\_\_

Time Returned \_\_\_\_\_

*Students: It is against school rules to forge, alter, or possess blank passes.*



# Nurse Pass

Student \_\_\_\_\_ Date \_\_\_\_\_

Teacher \_\_\_\_\_ Time \_\_\_\_\_

Reason for Sending \_\_\_\_\_

\_\_\_\_\_

Remarks \_\_\_\_\_

\_\_\_\_\_

Initials \_\_\_\_\_

---

# Nurse Pass

Student \_\_\_\_\_ Date \_\_\_\_\_

Teacher \_\_\_\_\_ Time \_\_\_\_\_

Reason for Sending \_\_\_\_\_

\_\_\_\_\_

Remarks \_\_\_\_\_

\_\_\_\_\_

Initials \_\_\_\_\_

---

# Nurse Pass

Student \_\_\_\_\_ Date \_\_\_\_\_

Teacher \_\_\_\_\_ Time \_\_\_\_\_

Reason for Sending \_\_\_\_\_

\_\_\_\_\_

Remarks \_\_\_\_\_

\_\_\_\_\_

Initials \_\_\_\_\_



# School Health Services Physical Activity Restriction

Student \_\_\_\_\_ Date \_\_\_\_\_

School \_\_\_\_\_ Phone \_\_\_\_\_ FAX \_\_\_\_\_

Grade \_\_\_\_\_ Birthdate \_\_\_\_\_ School Nurse \_\_\_\_\_

This student has a health condition which may be affected by physical activity and will be in a class which plans activities both in and out to the school building.

Please provide this update to the school regarding current status, health plan, and guideline for their activity level during sports, PE class, recess, or field trip outings.

### PHYSICIAN STATEMENT

Diagnosis:

Plan:

Will this student's activities be restricted?  Yes  No

If yes, explain (length of time; describe restriction in detail).

Date \_\_\_\_\_ Signature \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_



# FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

FORMS

520 Fifth Ave. Fairbanks, Alaska 99701-4756 (907) 452-2000

Days 1 - 15

MONTH: \_\_\_\_\_

## FAHRENHEIT (°F) TEMPERATURE LOG

REFRIGERATOR		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Staff Initials																
Time																
Day of Month																
°F Temp																
≥49																
48																
47																
46																
45																
44																
43																
42																
41																
40																
39																
38																
37																
36																
35																
34																
33																
≤32																
FREEZER																
≥8																
7																
6																
5																
4																
≤3																

**Instructions:** Place an "X" in the box that corresponds with the temperature (rows), day of the month, and am or pm (columns) for your temperature check. Then enter your initials and the time you monitored the temperature in the boxes at the top of the chart.

**If the temperature is in the gray range:**

1. Store the vaccine under proper conditions as quickly as possible.
2. Call the vaccine manufacturers to determine whether the potency of the vaccines has been affected, and
3. Call the immunization program at your local health department for further assistance: ( \_\_\_\_\_ )



# FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

FORMS

520 Fifth Ave. Fairbanks, Alaska 99701-4756 (907) 452-2000

Days 16 - 31

MONTH: \_\_\_\_\_

## FAHRENHEIT (°F) TEMPERATURE LOG

REFRIGERATOR		16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Staff Initials	Time																
Day of Month																	
°F T. mp	am   pm																
≥49																	
48																	
47																	
46																	
45																	
44																	
43																	
42																	
41																	
40																	
39																	
38																	
37																	
36																	
35																	
34																	
33																	
≤32																	
FREEZER																	
≥8																	
7																	
6																	
5																	
4																	
≤3																	

**Instructions:** Place an "X" in the box that corresponds with the temperature (rows), day of the month, and am or pm (columns) for your temperature check. Then enter your initials and the time you monitored the temperature in the boxes at the top of the chart.

**If the temperature is in the gray range:**

1. Store the vaccine under proper conditions as quickly as possible.
2. Call the vaccine manufacturer's toll-free number for the potency of the vaccine has been affected, and
3. Call the immunization program at your local health department for further assistance: (\_\_\_\_\_) \_\_\_\_\_



**FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT**

520 Fifth Ave. Fairbanks, Alaska 99701-4756 (907) 452-2000

**Authorization for Exchange/Release of Information**

Date \_\_\_\_\_

**PURPOSE OF THIS FORM**

In order for the Fairbanks North Star Borough School District to provide adequate planning for and service delivery to your child, it is necessary for us to obtain relevant records from previous schools and/or other agencies, organizations, and medical personnel who serve your child. It is also important for us to share information with these agencies or individuals. Your signature on this form authorizes FNSBSD to initiate these procedures.

**STUDENT DATA**

Name \_\_\_\_\_ DOB \_\_\_\_\_

Other names the student has used \_\_\_\_\_

Last school attended \_\_\_\_\_

Agency(ies) permitted to release/exchange data \_\_\_\_\_

**SEND INFORMATION TO**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**RECORDS REQUESTED**

	<b>Section A: School Records</b>		<b>Section B: Special Education Records</b>
	Basic state mandated cumulative records		Medical records
	Health records		Psychological records and other assessment data
	Grade and/or credits		Speech and hearing records
	Standardized test results		Student's Individual Education Program (IEP)
	Vocational interest inventory/tests		All of the above
	Activities records		<b>Section C: Special Education Records</b>
	Awards and Scholarships		
	All of the above		

**PARENTAL PERMISSION**

I hereby authorize the release of records (as indicated in sections A, B and C above) and any ongoing exchange of relevant information needed for case planning and service delivery. I understand that I may receive from the school district, upon written request and at my expense, a copy of any of the above records. These records are subject to interpretation by appropriate school personnel. The contents of the records are open to my review and challenge (see Due Process Rights form).

Signed \_\_\_\_\_ Date \_\_\_\_\_  
 (Parent/Guardian/Eligible Student)





# FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

520 Fifth Ave. Fairbanks, Alaska 99701-4756 (907) 452-2000

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## RINGWORM

Date \_\_\_\_\_

Dear Parent/Guardian:

\_\_\_\_\_ has a rash which I believe is ringworm. The instructions below may help you handle this health problem.

Ringworm is not a worm, but an infection caused by a fungus-

- Ringworm can be treated with tinactin or micatin, which you can buy without a prescription. Read and follow the directions for applying the medicine.
- Do not allow your child to let others wear his/her clothes or hats unless they are washed first. Do not share combs or brushes with your child or with other people in the household.
- Except for a bath, keep your child's skin dry, as wet skin makes the rash worse.
- Keep your child's fingernails clean and cut short to keep him/her from spreading the rash.
- The infection is not contagious after two days of treatment. Your child can go to school if treatment has begun. Keep the ringworm covered.
- Ringworm can be caught from a cat or dog. If you have a pet, have a veterinarian check your animal.
- If the rash does not get better, or spreads to your child's head, take your child to the doctor.

\_\_\_\_\_  
School Nurse

\_\_\_\_\_  
Phone

### **Healthy Children Learn Better!**

*Fairbanks North Star Borough School District nurses are doing their part.  
Thank you for doing yours.*



# FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

520 Fifth Ave. Fairbanks, Alaska 99701-4756 (907) 452-2000



## SCABIES

Date \_\_\_\_\_

Dear Parent/Guardian:

\_\_\_\_\_ was seen by the school nurse for a rash which we believe might be scabies. Scabies is caused by tiny insects (arachnids) called mites that burrow under the skin causing a rash to appear. The mite is so small, it requires a microscope to be seen. An itchy rash, the tell-tale sign of scabies, can be very bad at night. In school-age children, the rash appears between the fingers and on the wrists, elbows, armpits, and beltline.

***Do not panic!*** Anyone can get scabies. It is not a sign of having poor health habits or being dirty. Mites are passed from one person to another by prolonged skin-to-skin contact. Mites are rarely caught from casual activities such as hand holding during games. However, sleeping in the same bed and/or two children wrestling may provide a means for transmission.

### **SIGNS OF SCABIES**

Severe itching is the most typical sign of scabies. Because it is particularly bad at night, infants and young children with scabies are often fretful and sleep poorly.

The rash is a lot of small red or white bumps, and sometimes blisters, hives, and crusty sores appear. In school-age children and adults, you will often see the rash between the fingers and on the wrists, elbows, armpits, breasts, beltline, groin, and genitals. The palms, soles, and face are almost never involved.

### **TO GET RID OF THE SCABIES MITE**

1. A prescription medicine is necessary to clear it up. You will need to take your child to the doctor.
2. Check all other family members to see if they are infested. Any family member with evidence of scabies must be treated.
3. Wash all bed linens, towels, and underwear in hot water. (Mites can survive for 3 to 4 days off the human skin.)

***UPON RETURN TO SCHOOL, YOUR CHILD MUST BRING A NOTE FROM YOUR DOCTOR AS PROOF OF TREATMENT.***

\_\_\_\_\_  
School Nurse

\_\_\_\_\_  
Phone

**Healthy Children Learn Better!**

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Thank you for doing yours!





# FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

520 Fifth Ave. Fairbanks, Alaska 99701-4756 (907) 452-2000

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## SCOLIOSIS SCREENING REFERRAL TO PARENT

Name \_\_\_\_\_ Grade \_\_\_\_\_  
 School \_\_\_\_\_ Teacher \_\_\_\_\_

Dear Parent/Guardian:

Your child was given a posture check to screen for scoliosis (curvature of the spine) by the school nurse as one of the health services provided by this school system. Your child appears to have a possible curvature of the spine. The nurse's findings are attached to this letter.

It is advised that you have your child further checked by your family doctor or pediatrician. The doctor who further checks your child will advise you if treatment is necessary. Early treatment can often prevent a progressive spine deformity.

- Please take the attached form with you when you take your child for the evaluation.
- Have the health professional fill out the results of the exam, and return the completed form to the above address.
- If your child is already receiving treatment for scoliosis from a health professional, please complete the following information:

Physician \_\_\_\_\_ Phone \_\_\_\_\_

Date you child was last examined for this problem \_\_\_\_\_

School Nurse \_\_\_\_\_

Phone \_\_\_\_\_

**Healthy Children Learn Better!**

*Fairbanks North Star Borough School District nurses are doing their part.  
 Thank you for doing yours.*

**DEAR PARENT/GUARDIAN:**

**THE SCHOOL NURSING STAFF WILL BE SCREENING FOR SCOLIOSIS. THIS SCREENING IS DONE ANNUALLY ON ALL STUDENTS GRADES 5 THROUGH 10. BOYS SHOULD WEAR A SHIRT THAT CAN BE EASILY REMOVED, AND GIRLS SHOULD WEAR OR BRING A BUTTONED BLOUSE THAT CAN BE WORN BACKWARD SO ONLY HER BACK WILL BE EXPOSED.**

**SCOLIOSIS IS A SIDEWARD CURVATURE OF THE SPINE. ONSET IS PAINLESS AND APPEARS GRADUALLY, ESPECIALLY DURING YEARS OF RAPID TEENAGE GROWTH. IT IS OFTEN CONFUSED WITH POOR POSTURE. SOME CASES ARE SO MILD AS TO NOT NEED MEDICAL ATTENTION, BUT OTHERS GET PROGRESSIVELY WORSE AS THE CHILD GROWS. EARLY DETECTION AND REFERRAL MAY PREVENT FURTHER CURVATURE.**

**IF A PROBLEM IS FOUND DURING YOUR CHILD'S EXAM, YOU WILL RECEIVE A REFERRAL LETTER. PLEASE CALL ME IF YOU HAVE ANY QUESTIONS.**

**NURSE \_\_\_\_\_ PHONE \_\_\_\_\_**

**SCHOOL \_\_\_\_\_**

**DATE OF SCREENING \_\_\_\_\_**



**SCOLIOSIS SCREENING REFERRAL TO PARENT**

Student \_\_\_\_\_

School \_\_\_\_\_

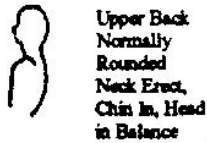
School Nurse \_\_\_\_\_

Phone \_\_\_\_\_

*Findings Circled*

*Described*

**SIDE VIEW**



Upper Back Normally Rounded  
Neck Erect, Chin In, Head in Balance



Upper Back Slightly More Rounded  
Neck Slightly Forward, Chin Slightly Out



Upper Back Markedly Rounded  
Neck Markedly Forward, Chin Markedly Out

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**HIGH SHOULDER**



Shoulders Level (Horizontally)



One Shoulder Slightly Higher Than Other



One Shoulder Markedly Higher Than Other

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**CURVED SPINE**



Spine Straight



Spine Slightly Curved Laterally



Spine Markedly Curved Laterally

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**HIGH HIP**



Hips Level (Horizontally)



One Hip Slightly Higher



One Hip Markedly Higher

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**LUMBAR PROMINENCE RIB HUMP**



Normal Symmetrical



Abnormal Asymmetrical



Normal Symmetrical



Abnormal Asymmetrical

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PHYSICIANS' FINDINGS AND RECOMMENDATIONS**

I have examined \_\_\_\_\_ on date \_\_\_\_\_

( ) x-ray needed \_\_\_\_\_

( ) No significant findings at this time \_\_\_\_\_

( ) Need for further evaluation \_\_\_\_\_

( ) Re-examination or treatment recommended (If so, date \_\_\_\_\_)

Comments \_\_\_\_\_

\_\_\_\_\_

Physician's Signature

Phone Number



# FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

520 Fifth Ave. Fairbanks, Alaska 99701-4756 (907) 452-2000

## Scoliosis Screening Referral

Date \_\_\_\_\_

Student \_\_\_\_\_

School \_\_\_\_\_

Dear Parent/Guardian:

Your child was screened for scoliosis (spinal curvature) on \_\_\_\_\_. The results were:

- Spinal Curvature
- Shoulder Elevation
- Shoulder Blades Uneven
- Hips Uneven
- Rib Prominence
- Other \_\_\_\_\_

It is recommended your child have an evaluation by your medical provider. If you have any questions, call your school nurse at \_\_\_\_\_.

**PHYSICIAN, COMPLETE AND RETURN TO THE SCHOOL NURSE OR FAX \_\_\_\_\_.**

Diagnosis \_\_\_\_\_

Recommendation \_\_\_\_\_

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Date



FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

520 Fifth Ave. Fairbanks, Alaska 99701-4756 (907) 452-2000

Fairbanks North Star Borough School District

Spinal Screening Flow Sheet (optional use)			SPINAL SCREENING FLOW SHEET											
School _____ Grade _____ Date _____ Screener(s) _____														
Student	Sex	A - Shoulder B - Spine C - Scapula						Hip	Chest Cage Hump	Back: R - Round S - Sway	Spine Hump	Under med. Tx Y/N	No Follow Up Necessary (normal)	Rescore n

Diagnosis Code: S - Scoliosis  
 N - Normal  
 O - Other  
 Treatment Code: O - Observation  
 B - Brace  
 S - Surgery  
 U - Unknown/None





# FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

520 Fifth Ave. Fairbanks, Alaska 99701-4756 (907) 452-2000

## SEIZURE STATUS UPDATE

Dear Parent/Guardian:

It has been noted on your child's health record that he/she has *seizures*. It is important to have current health information and direction when your child needs help at school. Please complete this form, and return it to school tomorrow so the school nurse may give appropriate instructions to school personnel about your child.

How often do the seizures occur?

Does your child experience an aura prior to onset of a seizure?  No  Yes (what: \_\_\_\_\_)

Has hospitalization been needed in the past year for seizures?  No  Yes (when: \_\_\_\_\_)

Seizures are currently being treated by Dr. \_\_\_\_\_ Phone \_\_\_\_\_

What does the seizure usually look like and how long does it last? \_\_\_\_\_

List conditions which generally cause the seizure (e.g., noise, blinking lights) \_\_\_\_\_

Does your child need any special activity adaptations/protective equipment (e.g., helmet) at school? \_\_\_\_\_

No  Yes (Explain \_\_\_\_\_)

How long after a seizure before your child can return to regular activities? \_\_\_\_\_

Are medications needed to control the seizures?  No  Yes (List the medications.)

**MEDICATIONS	AMOUNT TAKEN	HOW OFTEN AND FOR WHAT SIGNS?
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

Circle the number of any of these medications to be taken at school.

Attached is an individual health care plan detailing our usual procedure to follow at school for a student who is seizing. If you want additional help given, describe action(s) here: \_\_\_\_\_

Other comments or special directions: \_\_\_\_\_

\*\*Tests, medications, and activity restrictions require written direction from the student's doctor.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Daytime Phone \_\_\_\_\_



FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

FORMS

520 Fifth Ave. Fairbanks, Alaska 99701-4756 (907) 452-2000

**SEIZURE REPORT FLOW CHART**

	Date of Each Seizure			
	Time of Onset			
	Total Time Involved			
<b>OBSERVATION BEFORE SEIZURE</b>				
	cries out			
	other			
<b>OBSERVATION DURING SEIZURE</b>				
<b>Extremity involvement:</b>	both upper and lower			
<b>Arms affected</b>	right			
	left			
<b>Legs affected</b>	right			
	left			
	straight			
	bent			
	stiff			
	limp			
<b>Verbal sounds:</b>	before			
	during			
<b>Face twitching:</b>				
<b>Mouth:</b>	open			
	closed			
	grimacing			
<b>Drooling:</b>				
<b>Vomited:</b>				
<b>Eye Movement:</b>	staring			
	open			
	closed			
	fluttering			
	rolled back			
<b>Head:</b>	turned right			
	turned left			
	turned down			
	hyperextended back			
	nodding			
<b>Body-trunk:</b>	rigid			
	limp			
	sitting			
	laying			
	trembling			
	jerking			



# Seizure Report Flow Chart

Student Name		Grade	Class		
	standing				
Skin color:	pale				
	grey				
	blue				
Breathing:	red (flushed)				
	difficulty during				
	difficulty after				
	15 seconds				
Incontinent:	1 minute				
	longer (amount?)				
	urine				
	bowels				
<b>OBSERVATION AFTER SEIZURE</b>					
	drowsy				
	confused				
	sleep (length of time)				
Other:	injury (elaborate)				
	School Nurse called				
	Health Clerk called				
	Parent called				
	Child taken home				
	Doctor called				
	911 called				
	Responder initials				

Responder's Signature

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Source: *The School Nurse's Source Book of Individualized Health Care Plans*



## Shunt Obstruction Symptoms

<p><b>MILD</b></p>	<p>personality change          ↓ activity          changes in speech          ↓ school performance              hand-eye coordination -visual and motor              Jepson- Taylor, Frostig tests, etc.          ↓social relationships          ↑ eating and weight loss          ↓ eating and weight gain seizures          ↑ incontinence          recurring headache          ↓ visual acuity          papilledema          strabismus          spasticity of lower extremities          worsening scoliosis          ↑ OFC          temperature elevation</p>
<p><b>MODERATE</b></p>	<p><i>In addition to above:</i>          persistent headache-frontal "behind eyes"          emesis-infrequent          ↓ responsive to lethargy alternating with irritability</p>
<p><b>SEREVE</b></p>	<p>somnolence -difficult to arouse          pain or headache down neck          opisthotonis          emesis is constant          refusal to eat          pupils still react, but may be sluggish</p>
<p><b>CRITICAL</b></p>	<p>coma or barely responsive          pupil dilation may be asymmetrical          survival vital signs change (BP T then ↑, pulse ↓ then ↑, RR irregular</p>



# FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

520 Fifth Ave. Fairbanks, Alaska 99701-4756 (907) 452-2000

## **Sickle Cell Anemia** *INDIVIDUAL HEALTH CARE PLAN*

**CONFIDENTIAL** FOR \_\_\_\_\_ DOB \_\_\_\_\_

Written on \_\_\_\_\_ By \_\_\_\_\_, RN (phone # \_\_\_\_\_)

\_\_\_\_\_ has a health condition you as his/her teacher needs to be aware. The description of this problem, as well as emergency care and individual considerations are stated below. Keep this information available for substitute teachers. Please contact me if you have any questions.

**MEDICAL DIAGNOSIS / CONDITION** *Sickle Cell Anemia / Sickle Cell Trait*

Sickle Cell Anemia is a congenital anemia that results from a defective molecule that causes red blood cells to roughen and become sickle-shaped. These sickle-shaped cells impair circulation, resulting in chronic fatigue, difficulty breathing on exertion, swollen joints, and premature death.

**SIGNS / SYMPTOMS**

- |                                                                                                   |                           |
|---------------------------------------------------------------------------------------------------|---------------------------|
| 1. Symptoms may be brought about by infection, stress, dehydration, strenuous exercise, and cold. |                           |
| 2. rapid heart beat                                                                               | 6. chest pain             |
| 3. chronic fatigue                                                                                | 7. aching bones           |
| 4. difficulty breathing                                                                           | 8. aching muscles         |
| 5. jaundice                                                                                       | 9. joint swelling         |
| 6. pallor                                                                                         | 10. severe abdominal pain |

**ACTION**

- In the event of chest pain, shortness of breath, or blue color to the lips and mouth area, sleepiness, and/or difficulty awakening, if student is able, send him/her to the office accompanied by a teacher or responsible student.  
CALL:
  - 9-1-1
  - Parent/guardian
  - school health services
- If severe pain occurs, contact parent/guardian. While you wait, apply warm compresses to painful areas and cover the child with a blanket. (Never use cold compresses, since this aggravates the condition.)
- During periods of activity, encourage fluid intake.

**INDIVIDUAL CONSIDERATION**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Parent(s): \_\_\_\_\_ Home: \_\_\_\_\_ Work: \_\_\_\_\_

\_\_\_\_\_ Home: \_\_\_\_\_ Work: \_\_\_\_\_

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_ Hospital: \_\_\_\_\_

Other Contact Person: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_



# FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

520 Fifth Ave. Fairbanks, Alaska 99701-4756 (907) 452-2000

## Sore Throat

Date \_\_\_\_\_

Dear Parent/Guardian:

\_\_\_\_\_ was seen by the school nurse for a sore throat. Here are some things that you can do at home to help your child feel better.

- Have your child drink at least 8 glasses of clear liquids like fruit juices and water. Sipping warm broth can also soothe the throat.
- For the relief of headache, sore throat, and/or fever, you may use a nonaspirin product such as Tylenol.
- DO NOT USE ASPIRIN.
- Sucking on sugar-free hard candy can help keep the throat moist.
- See your doctor if your child does not seem better in a few days or if the fever increases.
- Nurse comments: \_\_\_\_\_

\_\_\_\_\_  
School Nurse

\_\_\_\_\_  
Phone

### **Healthy Children Learn Better!**

*Fairbanks North Star Borough School District nurses are doing their part.*

Thank you for doing yours.



# FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

520 Fifth Ave. Fairbanks, Alaska 99701-4756 (907) 452-2000

## Special Education Department

Date \_\_\_\_\_ School \_\_\_\_\_

Student \_\_\_\_\_ Date of Birth \_\_\_\_\_

Dear Dr. \_\_\_\_\_

In order to implement a special education program for the above student, we need your signed certification that s/he fits the definition described below.

**OTHER HEALTH IMPAIRMENTS** 4 AAC 52.130.k

To be eligible for special education and related services as a child with other health impairments, a child must exhibit limited strength, vitality, or alertness due to chronic or acute health problems such as a heart condition, tuberculosis, rheumatic fever, nephritis, asthma, sickle cell anemia, hemophilia, epilepsy, lead poisoning, leukemia, diabetes, or ADD/ADHD. To be eligible, those problems must adversely affect that child's educational performance.

Signature \_\_\_\_\_

Position \_\_\_\_\_

***FOR PHYSICIAN'S USE***

The doctor's written statement must make reference to the medical condition and specify how it will affect educational performance in such terms as: limited strength, vitality, alertness, etc.

I have conducted a medical evaluation of \_\_\_\_\_  
on \_\_\_\_\_ which describes and confirms his/her health circumstances  
and which provides implications for educational planning, including

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_



# FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

520 Fifth Ave. Fairbanks, Alaska 99701-4756 (907) 452-2000

## Sport Physical Form

**PART A TO BE FILLED OUT BY ATHLETE**

NAME: \_\_\_\_\_ SCHOOL: \_\_\_\_\_ GRADE: \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_ SPORT(S): \_\_\_\_\_  
 PHONE NUMBER: \_\_\_\_\_ POSITION(S): \_\_\_\_\_  
 BIRTHDATE: \_\_\_\_\_ AGE: \_\_\_\_\_ COACH(ES): \_\_\_\_\_  
 NAME OF PARENTS: \_\_\_\_\_

Please check if you have had any problems in the following areas:

- |                                                    |                                             |                                                                 |
|----------------------------------------------------|---------------------------------------------|-----------------------------------------------------------------|
| <input type="checkbox"/> Concussion, "Knocked Out" | <input type="checkbox"/> Neck Injury        | <input type="checkbox"/> Back Injury, Pain                      |
| <input type="checkbox"/> Shoulder Injury           | <input type="checkbox"/> Arm, Elbow, Hand   | <input type="checkbox"/> Knee Injury, Popping                   |
| <input type="checkbox"/> Groin, Thigh, Leg Injury  | <input type="checkbox"/> Ankle, Foot Injury | <input type="checkbox"/> Swelling, Pain, Locking, or Giving Way |
- Yes No
- Have any members of your family under the age 40 had a "heart attack" or sudden death?  
 Have you ever had chest pain while exercising, or passed out?  
 Do you have cough, wheezing, or sever shortness of breath with exercise?  
 Are you taking any medication?  
 Do you have any allergies?  
 Have you had ear problems or difficulty hearing?  
 Do you wear glasses or contact lenses?  
 Have you ever had any discomfort in your groin (hernia)?  
 Have you ever had any illness or injuries that required hospitalization, surgery, or repeated visits to the doctor?

**PART B TO BE FILLED OUT BY PHYSICIAN**

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_  
 Eyes R 20/ \_\_\_\_\_ L 20/ \_\_\_\_\_ Ears \_\_\_\_\_ Skin \_\_\_\_\_ Lungs \_\_\_\_\_  
 Heart \_\_\_\_\_ Abdomen \_\_\_\_\_ Neurologic \_\_\_\_\_ Urinalysis (if indicated) \_\_\_\_\_

MEDICAL FINDINGS

RECOMMENDATIONS

Follow up with athlete's physician  
 (Other)

MUSCULOSKELETAL

RECOMMENDATIONS

- |                                                           |                                                             |
|-----------------------------------------------------------|-------------------------------------------------------------|
| <input type="checkbox"/> Neck Weakness                    | <input type="checkbox"/> Strengthen Exercises, Neck         |
| <input type="checkbox"/> Shoulder Weakness                | <input type="checkbox"/> Neck Roll (equipment)              |
| <input type="checkbox"/> Shoulder Injury                  | <input type="checkbox"/> Strengthening Exercises, Shoulders |
| <input type="checkbox"/> Scoliosis                        |                                                             |
| <input type="checkbox"/> Tight Hamstring                  | <input type="checkbox"/> Hamstring Stretching               |
| <input type="checkbox"/> Tight Groin Muscles              | <input type="checkbox"/> Groin Stretching                   |
| <input type="checkbox"/> Worn Knee Cap                    | <input type="checkbox"/> Quadriceps Strengthening           |
| <input type="checkbox"/> Knee Injury; Ligament, Cartilage | <input type="checkbox"/> Knee Brace                         |
| <input type="checkbox"/> Tight Achilles Tendon            | <input type="checkbox"/> Achilles Stretches                 |
| <input type="checkbox"/> Weak Ankles                      | <input type="checkbox"/> Strengthening Exercises, Ankles    |
|                                                           | <input type="checkbox"/> Tape or Wrap Ankles                |
|                                                           | <input type="checkbox"/> Referral to Orthopaedist           |
|                                                           | <input type="checkbox"/> Referral to Athletic Trainer       |
|                                                           | <input type="checkbox"/> (Other)                            |

CLEARANCE: Medical  Yes  No Musculoskeletal  Yes  No

I certify that I have on this date examined this patient and find him/her physically able to compete in supervised activities with restrictions noted.

Restrictions: \_\_\_\_\_  
 PHYSICIAN'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_  
 PHYSICIAN'S NAME (PLEASE PRINT) \_\_\_\_\_





# Summer School

## HEALTH INFORMATION/PERMISSION

Student	Date of Birth	
Home Address	Phone	
Father	Home Phone	Work Phone
Mother	Home Phone	Work Phone
Emergency Contact	Phone	
Physician	Phone	
Allergies	Symptoms	
Medications	Medication History	

### AUTHORIZATION FOR EMERGENCY MEDICAL CARE

I, \_\_\_\_\_ parent/guardian of \_\_\_\_\_ (child) authorize the school nurse to consent to any necessary emergency medical care for the above named child during any period I cannot be contacted during the time my child is at school. I understand an attempt will be made to contact me for consent prior to the school nurse authorizing emergency medical care to the above named child.

\_\_\_\_\_  
Parent/Guardian

\_\_\_\_\_  
Date

### INDIVIDUAL CONSIDERATION

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Parent(s): \_\_\_\_\_ Home: \_\_\_\_\_ Work: \_\_\_\_\_

\_\_\_\_\_ Home: \_\_\_\_\_ Work: \_\_\_\_\_

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_ Hospital: \_\_\_\_\_

Other Contact Person: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_





# FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

520 Fifth Ave. Fairbanks, Alaska 99701-4756 (907) 452-2000



## Tracheostomy

### INDIVIDUAL HEALTH CARE PLAN

**CONFIDENTIAL** FOR \_\_\_\_\_ DOB \_\_\_\_\_

Written on \_\_\_\_\_ By \_\_\_\_\_, RN (phone # \_\_\_\_\_)

\_\_\_\_\_ has a health condition you as his/her teacher needs to be aware. The description of this problem, as well as emergency care and individual considerations are stated below. Keep this information available for substitute teachers. Please contact me if you have any questions.

#### **MEDICAL DIAGNOSIS / CONDITION** *Tracheostomy / Possible Respiratory Distress*

A tracheostomy (trach) is a surgical opening into the windpipe (trachea) in the neck, that is created for student who is unable to breathe through the normal air passage. The trach allows air to go in and out of the lungs. The opening in the neck is called a stoma. A metal or plastic tube, called a tracheostomy tube, may be inserted through the stoma into the trachea. If present, the tube is secured with twill tape tied around the student's neck. The trach tube/stoma may or may not be covered.

Students with tracheostomies can attend regular classrooms. Some students can manage their own trach care others may need to be accompanied by a trained caregiver at all times while in the educational setting or during transport. Many students with trachs participate in regular school activities, with modifications that are determined by parents and doctor. Students with tracheostomies should avoid areas with a lot of dust or other airborne such as chalk dust. This is because the air the student breathes the lungs directly, without being filtered, ill and warmed by the nose and mouth. School personnel should be able to recognize the sighs of breathing difficulty and immediately know how to assist the student with a trach.

#### **SIGNS / SYMPTOMS**

1. bluish or unusually pale skin color
2. drowsiness, unconsciousness
3. labored breathing
4. inability to move air through trach
5. flared nostrils

#### **ACTION**

1. DO NOT leave student alone.
2. Call for assistance and delegate call to 9-1-1.
3. If student is unable to breath and worsening:
  - a. cut ties and remove trach tube
  - b. observe student's respiratory status
  - c. If student is breathing:
    - i. stay with student offering reassurance
    - ii. continue monitoring
  - d. If student is blue and/or in severe distress:
    - i. attempt MOUTH-TO-STOMA ventilation
    - ii. If MOUTH-TO-STOMA is unsuccessful, attempt MOUTH-TO-MOUTH occluding stoma with finger.



## Parent Notification of Tuberculin Testing

Date \_\_\_\_\_

Dear Parent/Guardian:

State law requires all kindergarten and seventh grade students and all students new to the Fairbanks North Star Borough School District to be tested for tuberculosis within 90 days of starting school.

On \_\_\_\_\_, your child \_\_\_\_\_, will get a tuberculin (TB) PPD skin test as mandated by state law. The results of the skin test will be read within 48- 72 hours.

You may assume the result of your child's skin test is *negative* unless you hear from me.

### ***TUBERCULIN SKIN TEST***

***What It Is*** It is a skin test which tells whether or not germs that cause tuberculosis are in the body.

***How It Works*** The nurse cleans the forearm with an alcohol swab, then injects a small amount of solution (PPD) under the very top layer of skin.

***What It Shows*** In 2 to 3 days after the test is given, the nurse will examine the arm. If there is no raised area, the test is negative.

If there is a raised area of 10 mm or more, further evaluation will be done.

\_\_\_\_\_  
Nurse

\_\_\_\_\_  
School

\_\_\_\_\_  
Phone

### **INDIVIDUAL CONSIDERATION**

\_\_\_\_\_  
\_\_\_\_\_  
Parent(s): \_\_\_\_\_ Home: \_\_\_\_\_ Work: \_\_\_\_\_

Work: \_\_\_\_\_

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_ Hospital: \_\_\_\_\_

Other Contact Person: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_



Fairbanks North Star Borough School District

# Tuberculin Test Permission Form

Dear Parent/Guardian:

State law requires all kindergarten and seventh grade students and all students new to the Fairbanks North Star Borough School District be tested for tuberculosis within 90 days of starting school.

### **TUBERCULIN SKIN TEST**

**What It Is** It is a skin test which tells whether or not germs that cause tuberculosis are in the body.

**How It Works** The nurse cleans the forearm with an alcohol swab, then injects a small amount of solution (PPD) under the very top layer of skin.

**What It Shows** In 2 to 3 days after the test is given, the nurse will examine the arm. If there is no raised area, the test is negative.

If there is a raised area of 10 mm or more, further evaluation will be done.

Please check one of the following, then **sign** and **return** the form to the school nurse as soon as possible.

\_\_\_\_\_ **YES**, I give my consent for \_\_\_\_\_ to have the required tuberculin test performed by the school nurse as needed during the period my child is enrolled in the Fairbanks North Star Borough School District .

\_\_\_\_\_ **NO**, I do not consent for \_\_\_\_\_ to have the required tuberculin test done at school. I will provide documentation of a PPD tuberculin test done on my child before \_\_\_\_\_.

(Date)

\_\_\_\_\_ My child, \_\_\_\_\_, already has a positive PPD tuberculin test. I will provide documentation to the school nurse before \_\_\_\_\_.

(Date)

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date





# FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

520 Fifth Ave. Fairbanks, Alaska 99701-4756 (907) 452-2000

## Positive Tuberculin Test SCHOOL NURSE REFERRAL/FOLLOW UP

\_\_\_\_\_, \_\_\_\_\_ had a positive PPD test on \_\_\_\_\_.  
(Student/Client) (DOB)

The result was \_\_\_\_\_ mm in size. Previous tuberculin status \_\_\_\_\_.  
(Date and Result)

I am referring this student/client to you for follow up.

\_\_\_\_\_  
School Nurse Date

\_\_\_\_\_  
School Phone FAX

Do you have any of the following symptoms:

- Cough that has lasted more than 2 weeks? \_\_\_\_\_ Yes \_\_\_\_\_ No
- Night sweats? \_\_\_\_\_ Yes \_\_\_\_\_ No
- Coughing up blood or blood-tinged sputum? \_\_\_\_\_ Yes \_\_\_\_\_ No
- Recent unexplained weight loss? \_\_\_\_\_ Yes \_\_\_\_\_ No

\*\*\*\*\*

**Health Care Provider -Fill out and return to the school nurse. Thank you.**

The above student/client was given these follow-up instructions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Chest X-Ray Date Result

This client is cleared to return to work \_\_\_\_\_ Yes \_\_\_\_\_ No

\_\_\_\_\_  
Public Health Nurse or Physician Date

## TUBERCULOSIS CONTROL PROGRAM QUESTIONNAIRE

(Checklist for persons who have a positive TB skin test or PPD and who have had one chest x-ray and medical evaluation.)

Complete this form to determine if a chest x-ray and referral for additional evaluation is needed.

YES	NO	
_____	<input type="checkbox"/>	1. Have you ever been ill with tuberculosis? a. If so, did you take medicine for it? b. Name of medication(s) c. How long did you take the medication(s)? d. Did you finish the medication(s) or treatment? e. Date of last chest x-ray f. Date of last doctor evaluation/checkup
_____	<input type="checkbox"/>	2. Have you ever had a positive tuberculin skin test? a. If so, did you take medicine for it? b. Name of medication(s) c. How long did you take the medication(s)? d. Did you finish the medication(s) or treatment? e. Date of last chest x-ray f. Date of last doctor evaluation/checkup
_____	_____	3. Has your TB skin test reading changed/increased in size in the past two years?
_____	_____	4. Have any members of your family/household or any close friends had tuberculosis in the past two years?
_____	_____	5. Do you have any of the following diseases or illnesses: a. diabetes (severe or poorly controlled)? b. silicosis? c. stomach surgery (gastrectomy) or weight loss due to undernutrition? d. any disease of lymph glands or immune system, such as cancer or leukemia? e. HIV/AIDS or unknown HIV status with risk factors for HIV? f. medical treatment with steroids, radiation, or x-ray therapy? g. alcohol use to an extent that it has caused a problem with your family, health, or job? h. severe kidney disease? i. use of intravenous drugs?
_____	_____	6. Do you now have any of the following symptoms: a. cough that has lasted more than two weeks? b. night sweats? c. recent unexplained weight loss? d. coughing up blood?
_____	_____	7. Were you born in a foreign country? If so, did you receive BCG? _____

\_\_\_\_\_  
(Client)

\_\_\_\_\_  
(Age)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Health Care Screener)

\_\_\_\_\_  
(Date)

**DISPOSITION:**

\_\_\_\_\_ Client does not need further evaluation.

\_\_\_\_\_ A copy of this form will be forwarded to the Section of Epidemiology, Division of Public Health. Patient is to be referred to private physician for an evaluation and chest x-ray.



# FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

520 Fifth Ave. Fairbanks, Alaska 99701-4756 (907) 452-2000

## Vision Referral

Date \_\_\_\_\_ School \_\_\_\_\_  
Student \_\_\_\_\_ DOB \_\_\_\_\_ Grade \_\_\_\_\_  
School Address \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Dear Parent/Guardian:

Your child recently had a vision screening as part of the health appraisal done by the school nurse. Results indicate a need for further examination by an eye specialist. Please make an appointment as soon as possible. The following results/observations were made:

<u>Snellen</u>	<u>Both Eyes</u>	<u>Right Eye</u>	<u>Left Eye</u>
without glasses	20/	20/	20/
with glasses	20/	20/	20/
Other: _____			

Nurse's Signature: \_\_\_\_\_

### EXAMINER'S REPORT

The following information and recommendation will be helpful to the school nurse and teacher. Please complete this form and return to the above listed school.

<u>Visual Acuity</u>	<u>Without Lenses</u>	<u>With Present Lenses</u>	<u>With Best Correction</u>
RE	RE	RE	RE
LE	LE	LE	LE

Diagnosis: \_\_\_\_\_

Wear Glasses: No \_\_\_\_\_ Yes \_\_\_\_\_ Constantly \_\_\_\_\_ In Class \_\_\_\_\_ For Reading Only \_\_\_\_\_

Suggestion: \_\_\_\_\_

Restriction: \_\_\_\_\_

Class Seating: \_\_\_\_\_

Prognosis: \_\_\_\_\_

Special Material: \_\_\_\_\_

Other Treatment: \_\_\_\_\_

Signature \_\_\_\_\_ Title \_\_\_\_\_

Date \_\_\_\_\_

Please return signed form to the nurse's office (address above).  
Information will remain on file in student's health folder.



# FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

520 Fifth Ave. Fairbanks, Alaska 99701-4756 (907) 452-2000

## ALASKA IMMUNIZATION REQUIREMENTS RELIGIOUS EXEMPTION FORM

Alaska Immunization Regulation 4 AAC 06.055, 4 AAC 62.450 and 4 AAC 60.100 require that all children in Alaska public/private schools, certified preschools, and licensed child care facilities be immunized against *pertussis* (for children less than 7 years of age), *diphtheria*, *tetanus*, *polio*, *measles*, *mumps*, *rubella*, *hepatitis A*, *hepatitis B*, *varicella* (for children in child care facilities and preschools and *Haemophilus influenzae type b* (for children less than 5 years of age in child care facilities or preschools), unless he/she is exempt for medical or religious reasons.

Religious exemption requests must contain the wording found in the Alaska Administrative Code [4AAC06.55 (b) (3) or 4AAC62.450(c) (2)] stating all vaccines must be received unless the child “has an affidavit signed by his [4AAC 62.450(c)(2) says “*the child’s*] parent or guardian affirming that immunization conflicts with the tenets and practices of the church or religious denomination of which the applicant[4 AAC 62.450 (c) (2) says “ *the parent or guardian*”] is a member.

If a RELIGIOUS exemption is requested, complete the information below and return this form to the school, preschool, or child care facility.

Name of Child \_\_\_\_\_ Birthdate \_\_\_\_\_

Name of Facility \_\_\_\_\_ Address \_\_\_\_\_ City \_\_\_\_\_ Telephone \_\_\_\_\_

NOTE: Personal or philosophical exemptions are not allowed under Alaska regulations.

**To be completed by the child’s parent or guardian.**

I/We affirm that immunization conflicts with the tenets and practices of the church or religious denomination of which the applicant is a member.

\_\_\_\_\_  
SIGNATURE OF PARENT OR GUARDIAN DATE

State of \_\_\_\_\_

Judicial District \_\_\_\_\_ SS.

The Foregoing Instrument was acknowledged before me by \_\_\_\_\_ on this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

Witness my hand and seal.

\_\_\_\_\_  
Notary Public (Signature)

\_\_\_\_\_  
Notary’s printed name  
My commission expires \_\_\_\_\_





# FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

520 Fifth Ave. Fairbanks, Alaska 99701-4756 (907) 452-2000

## REQUEST FOR ADMINISTRATION OF MEDICATION

If this form is properly completed and returned to the school nurse/principal, the Fairbanks North Star Borough School District may assist parents when their child's physician has prescribed medication for the child. The medication will only be given if it is delivered to the principal or his/her designee in the original bottle marked with the student's name, dosage, time of administration, physician, pharmacy, and date of purchase.

Student: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
School: \_\_\_\_\_ Grade: \_\_\_\_\_

### PHYSICIAN SECTION: (To be filled out by the physician)

Medication: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

Dosage and Time of Administration: \_\_\_\_\_

Discontinue Medication On: \_\_\_\_\_

For Inhalers, Students May Keep This on Their Person: Yes \_\_\_\_ No \_\_\_\_

Possible Side Effects:

- |                                        |                                           |
|----------------------------------------|-------------------------------------------|
| <input type="checkbox"/> aggression    | <input type="checkbox"/> loss of appetite |
| <input type="checkbox"/> edginess      | <input type="checkbox"/> sleep problems   |
| <input type="checkbox"/> headache      | <input type="checkbox"/> stomachache      |
| <input type="checkbox"/> jaw clenching | <input type="checkbox"/> weight loss      |

Other Medications Student is Taking: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician's Phone: \_\_\_\_\_

### PARENT/GUARDIAN STATEMENT:

As the parent/guardian (*circle one*) of the above-named student, I do hereby request the school district give medication to the above-named student. I understand that the school district is not legally obligated to administer medication to the student, and in the absence of the school nurse, other school personnel may administer the medication. I agree not to institute suit against the school district for administration or nonadministration of the medication, to defend and hold the school district harmless from any liability resulting from the administration or nonadministration of the medication, and to defend and indemnify the school and its employees from any liability arising out of this agreement. I will notify the school nurse/principal immediately if the medication is changed. **I give my permission for the exchange/release of medical information regarding the above student/treatment.**

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

### SCHOOL ACKNOWLEDGMENT:

School Nurse: \_\_\_\_\_ Date: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Rx Number: \_\_\_\_\_ Date: \_\_\_\_\_

Physician's Name (please print): \_\_\_\_\_



## RINGWORM

Date \_\_\_\_\_

Dear Parent/Guardian:

\_\_\_\_\_ has a rash which I believe is ringworm. The instructions below may help you handle this health problem.

Ringworm is not a worm, but an infection caused by a fungus.

- \* **Ringworm can be treated with tinactin or micatin, which you can buy without a prescription. Read and follow the directions for applying the medicine.**
- \* **Do not allow your child to let others wear his/her clothes or hats unless they are washed first. Do not share combs or brushes with your child or with other people in the household.**
- \* **Except for a bath, keep your child's skin dry, as wet skin makes the rash worse.**
- \* **Keep your child's fingernails clean and cut short to keep him/her from spreading the rash.**
- \* **The infection is not contagious after two days of treatment. Your child can go to school if treatment has begun. Keep the ringworm covered.**
- \* **Ringworm can be caught from a cat or dog. If you have a pet, have a veterinarian check your animal.**
- \* **If the rash does not get better, or spreads to your child's head, take your child to the doctor.**

\_\_\_\_\_  
School Nurse

\_\_\_\_\_  
Phone

**Healthy Children Learn Better!**

*Fairbanks North Star Borough School District nurses are doing their part.*

*Thank you for doing yours.*

## SCHOOL EMERGENCY CARE PLAN Evaluation Instrument

F - Fully Met



# FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

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P - Partially Met  
 U - Unmet  
 NA - Not Applicable

Evaluation Checklist	Status	Comments
The school district has written policies for emergency care.		
Policies are kept current.		
Policies are approved by the school administration and the school medical advisor.		
Policies are coordinated with the local EMS services and hospital services.		
Policies are distributed to all school employees and students.		
Duties of school employees in handling emergencies are clearly defined in written policy.		
Responsibilities are based on qualifications of an employee to provide emergency care.		
Coordinator or manager of emergency situations has been designated within each building.		
All employees are expected to give immediate care during an emergency and follow an action plan for calling for additional help.		
School nurse provides emergency care.		
School medical advisor is available for consultation in emergencies.		
At least one individual (other than the nurse) is qualified in first aid and CPR.		
Teachers working in high risk areas (labs, gyms, shops, etc.) are trained in first aid.		
A staff person will stay with an injured/seriously ill student until the parent/guardian assumes responsibility.		
Inservice training is provided to maintain adequate level of skills for employees designated to provide emergency care.		
Written action plan has been developed to initiate appropriate emergency care.		



# FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

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Evaluation Checklist	Status	Comments
Emergency telephone numbers are displayed near all phones.		
All employees are familiar with emergency numbers.		
Emergency information for each student/employee is kept current and available in a central location (phone # of parent/guardian, spouse/nearest relative, preferred hospital, physician, dentist).		
At least one school employee is designated to notify parent/guardian of an injured or seriously ill		
Transportation of an injured or ill student is clearly stated in written policy.		
Parents are notified of their responsibilities for transporting <b>an ill/injured child home for further</b>		
An alternate plan has been developed to transport a child if parent/guardian is unavailable.		
Coordination has been established with the local emergency medical transportation system.		
Written standing orders are maintained for common emergency problems.		
School medical advisor reviews standing orders annually.		
Standing orders are posted in appropriate areas.		
Emergency care supplies and equipment are adequate to meet needs.		
Selection of supplies and equipment is based on needs of school population and recommendations of school health personnel.		
First aid kits are available in central locations, high risk areas, and at extra curricular activities.		
Accident reports are completed and filed according to written policy.		
All accidents, including any emergency care given, are documented in an organized format.		
A school employee is designated to complete accident reports and maintain files.		
Accident reports are reviewed on a regular basis to revise policy and remedy hazards.		



# FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

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Evaluation Checklist	Status	Comments
Financial responsibility for charges incurred during emergency care has been stated in written policy.		
Health/accident insurance is <b>available for students</b> .		
School district maintains adequate liability insurance for injuries or accidents at school functions.		
School employees providing emergency care have personal liability insurance.		
Plan for follow up is described in written policies.		
School employee is designated to contact parent/guardian following the emergency within 24 hours.		
Communication between school and home/physician is maintained during recuperative period.		
Readmission to school requires a note from the physician which details any restrictions.		

## SCHOOL HEALTH SERVICES REFERRAL MEDICAL EVALUATION

Fairbanks North Star Borough School District

Student \_\_\_\_\_ Date \_\_\_\_\_

School \_\_\_\_\_ Phone \_\_\_\_\_ FAX \_\_\_\_\_



FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

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Grade \_\_\_\_\_ Teacher \_\_\_\_\_ DOB \_\_\_\_\_ Last Td \_\_\_\_\_

Reason for Referral \_\_\_\_\_

S.

O.

A.

P.

Nurse's Signature \_\_\_\_\_

**PHYSICIAN STATEMENT**

Diagnosis:

Plan:

When may this student return to school?

Will this student's activities be restricted?  Yes  No

If yes, explain (length of time; describe restriction in detail)?

Date \_\_\_\_\_

Signature \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_

**Please return this form to the school nurse either by mail, FAX, or with the student.**



# FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

520 Fifth Ave. Fairbanks, Alaska 99701-4756 (907) 452-2000

## SCHOOL HEALTH SERVICES PHYSICAL ACTIVITY RESTRICTION

Fairbanks North Star Borough School District

Student \_\_\_\_\_ Date \_\_\_\_\_  
 School \_\_\_\_\_ Phone \_\_\_\_\_ FAX \_\_\_\_\_  
 Grade \_\_\_\_\_ Birthdate \_\_\_\_\_ School Nurse \_\_\_\_\_

This student has a health condition which may be affected by physical activity and will be in a class which plans activities both in and out to the school building.

Please provide this update to the school regarding current status, health plan, and guidelines for their activity level during sports, PE class, recess, or field trip outings.

### PHYSICIAN STATEMENT

Diagnosis:

Plan:

Will this student's activities be restricted?  Yes  No

If yes, explain (length of time; describe restriction in detail)?

Date \_\_\_\_\_ Signature \_\_\_\_\_  
 Address \_\_\_\_\_  
 Telephone \_\_\_\_\_

**Please return this form to the school nurse either by mail, FAX, or with the student.**



# FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

520 Fifth Ave. Fairbanks, Alaska 99701-4756 (907) 452-2000

## SCOLIOSIS SCREENING REFERRAL TO PARENT

Name \_\_\_\_\_ Grade \_\_\_\_\_  
School \_\_\_\_\_ Teacher \_\_\_\_\_

Dear Parent/Guardian:

Your child was given a posture check to screen for scoliosis (curvature of the spine) by the school nurse as one of the health services provided by this school system. Your child appears to have a possible curvature of the spine. The findings are attached to this letter.

It is advised that you have your child checked by your family doctor or pediatrician. The doctor whom further checks your child will advise you if treatment is necessary. Early treatment can often prevent a progressive spine deformity.

- ✓ Please take the attached form with you when you take your child for the evaluation.
- ✓ Have the health professional fill out the results of the exam, and return the completed form to the above address.
- ✓ If you child is already receiving treatment for scoliosis from a health professional, please complete the following information:

Physician's Name \_\_\_\_\_  
Physician's Phone Number \_\_\_\_\_  
Date your child was last examined for this problem \_\_\_\_\_

If you have any questions, please call me at \_\_\_\_\_.

*Healthy Children Learn Better.  
Fairbanks North Star Borough School District nurses are doing their part.  
Thank you for doing yours.*

School Nurse

### SCOLIOSIS REFERRAL TO PHYSICIAN

Student \_\_\_\_\_ School \_\_\_\_\_  
School Nurse \_\_\_\_\_ Phone \_\_\_\_\_

**Findings Circled**

**Described**

Please return the form to the school nurse or FAX \_\_\_\_\_.

## MEDICAL HISTORY QUESTIONNAIRE

### Identifying Data

Student \_\_\_\_\_ Date \_\_\_\_\_





# FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

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School \_\_\_\_\_ Grade \_\_\_\_\_ Teacher \_\_\_\_\_  
DOB \_\_\_\_\_ Age \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_  
Home Address \_\_\_\_\_ Phone \_\_\_\_\_

### School Profile

Student's Attitude Toward School \_\_\_\_\_  
Parent's Attitude Toward School \_\_\_\_\_  
Schools Attended \_\_\_\_\_  
Attendance: Absenteeism \_\_\_\_\_ Reason \_\_\_\_\_  
Extra-Curricular Activities \_\_\_\_\_

### Family History

Father \_\_\_\_\_ Age \_\_\_\_\_ Occupation \_\_\_\_\_  
Work Phone \_\_\_\_\_  
Health Concerns \_\_\_\_\_  
Mother \_\_\_\_\_ Age \_\_\_\_\_ Occupation \_\_\_\_\_  
Work Phone \_\_\_\_\_  
Health Concerns \_\_\_\_\_  
Others Living in the Home  
Name \_\_\_\_\_ -Age \_\_\_\_\_ Relationship \_\_\_\_\_  
Health Concerns \_\_\_\_\_

### Family Medical History

Arthritis \_\_\_\_\_ Asthma \_\_\_\_\_ Allergies \_\_\_\_\_ Blood Dyscrasia \_\_\_\_\_ Cancer \_\_\_\_\_ Diabetes \_\_\_\_\_  
Chemical Use/Dependency \_\_\_\_\_ Cogential Abnormalities \_\_\_\_\_ Heart Disease \_\_\_\_\_  
Hypertension \_\_\_\_\_ Kidney Disease \_\_\_\_\_ Mental Health Problem \_\_\_\_\_ Obesity \_\_\_\_\_ Seizures \_\_\_\_\_  
Rheumatic Fever \_\_\_\_\_ Smoking \_\_\_\_\_ Tuberculosis \_\_\_\_\_ Ulcers \_\_\_\_\_  
Other \_\_\_\_\_

### Prenatal History

# of Pregnancies \_\_\_\_\_ # of Live Births \_\_\_\_\_  
Complications during any pregnancy \_\_\_\_\_  
Infections during pregnancy \_\_\_\_\_  
Smoking \_\_\_\_\_ Alcohol Consumption During Pregnancy \_\_\_\_\_ Use of Prescription Drugs \_\_\_\_\_  
Recreational Drugs \_\_\_\_\_

### Information about Your Child's Birth

Length of Gestation (Weeks) \_\_\_\_\_ Labor (spontaneous, induced) \_\_\_\_\_  
Length of Labor \_\_\_\_\_ Delivery Type \_\_\_\_\_  
Anesthesia or Sedation \_\_\_\_\_ Birth: Weight \_\_\_\_\_ Apgar Score \_\_\_\_\_  
Complications or Other Medical Interventions \_\_\_\_\_



**FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT**

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**Neonatal**

Health Problems After the Birth \_\_\_\_\_  
 Age at Time of Discharge from Hospital \_\_\_\_\_  
 Feeding Problems \_\_\_\_\_

**Developmental**

Milestones: Sat Alone \_\_\_\_\_ Crawled \_\_\_\_\_ Walked \_\_\_\_\_ Stood \_\_\_\_\_ First Word \_\_\_\_\_  
 Toilet Trained \_\_\_\_\_ Dressed Self \_\_\_\_\_ Fed Self \_\_\_\_\_  
 Growth/Development as Compared to other Children/Siblings \_\_\_\_\_  
 Periods of Failure to Grow or unusual Growth \_\_\_\_\_

**Illness**

Acute (Infections: type, medication, treatment, etc) \_\_\_\_\_  
 Chronic \_\_\_\_\_  
 Medications over a Long Period of Time \_\_\_\_\_  
 High Temperature \_\_\_\_\_ History of Ear Infections \_\_\_\_\_ Difficulty with Speech \_\_\_\_\_  
 Immunizations (current) \_\_\_\_\_ YES \_\_\_\_\_ NO. If NO, what is needed? \_\_\_\_\_  
 Hospitalizations \_\_\_\_\_ Accidents (head injury, etc) \_\_\_\_\_

**Nutritional Profile**

Breakfast	Lunch	Dinner
Snacks	Vitamin Supplements	Favorite Foods
Dislikes	Food Allergies	

**Personality Profile**

Self Concept: Strengths \_\_\_\_\_  
 Weaknesses (overactive, underactive, compulsive) \_\_\_\_\_  
 Ability to Cope with Stress \_\_\_\_\_ Follows Directions \_\_\_\_\_ Easily Distracted \_\_\_\_\_  
 Periods of Depression \_\_\_\_\_ Lack of Verbal Interaction \_\_\_\_\_

Person Completing This Record \_\_\_\_\_  
 Relationship to Child \_\_\_\_\_

**SEIZURE STATUS UPDATE**



FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

520 Fifth Ave. Fairbanks, Alaska 99701-4756 (907) 452-2000

Dear Parent/Guardian:

It has been noted on your child's health record that he/she has seizures. It is important to have current health information and direction when your child needs help at school. Please complete this form, and return it to school tomorrow so the school nurse may give appropriate instructions to school personnel about your child.

How often do the seizures occur? \_\_\_\_\_

Does your child experience an aura prior to onset of a seizure?  No  Yes-What? \_\_\_\_\_

Has hospitalization been needed in the past year for seizures?  No  Yes-When? \_\_\_\_\_

Seizures are currently being treated by Dr. \_\_\_\_\_ Phone \_\_\_\_\_

What does the seizure usually look like and how long does it last? \_\_\_\_\_

List conditions which generally cause the seizure (e.g., noise, blinking lights) \_\_\_\_\_

Does your child need any special activity adaptations/protective equipment (e.g., helmet) at school? \_\_\_\_\_

No  Yes (Explain \_\_\_\_\_)

How long after a seizure before your child can return to regular activities? \_\_\_\_\_

Are medications needed to control the seizures?  No  Yes (List the medications.)

Medications **	Amount Taken	How Often and For What Signs

Circle the above medication taken at school.

Attached is an individual health care plan detailing our usual procedure to follow at school for a student who is seizing. If you want additional help given, describe action(s) here: \_\_\_\_\_

Other comments or special directions: \_\_\_\_\_

\*\*Tests, medications, and activity restrictions require written direction from the student's doctor.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Daytime Phone \_\_\_\_\_

**SHUNT OBSTRUCTION SYMPTOMS**



<b>MILD</b>	<p>personality change            ↓ activity            changes in speech            ↓ school performance                hand-eye coordination - visual and motor                Jepson-Taylor, Frostig tests, etc.            ↓ social relationships            ↑ eating and weight loss            ↓ eating and weight gain            seizures            ↑ incontinence            recurring headache            ↓ visual acuity            papilledema            strabismus            spasticity of lower extremities            worsening scoliosis            ↑ OFC            temperature elevation</p>
<b>MODERATE</b>	<p><i>In addition to above:</i>            persistent headache-frontal “behind eyes”            emesis-infrequent            ↓ responsive to lethargy alternating with irritability</p>
<b>SEVERE</b>	<p>somnolence - difficult to arouse            pain or headache down neck            opisthotonis            emesis is constant            refusal to eat            pupils still react, but may be sluggish</p>
<b>CRITICAL</b>	<p>coma or barely responsive            pupil dilation may be asymmetrical            survival vital signs change (BP ↑ then ↓, pulse ↑ then ↓, RR irregular)</p>

**SICKLE CELL ANEMIA**  
 (Individual Health Care Plan)

FOR \_\_\_\_\_

DOB \_\_\_\_\_



# FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

FORMS

520 Fifth Ave. Fairbanks, Alaska 99701-4756 (907) 452-2000

Written on \_\_\_\_\_ by \_\_\_\_\_, RN Phone \_\_\_\_\_

\_\_\_\_\_ has a health condition you as his/her teacher needs to be aware. The description of this problem, as well as emergency care and individual considerations are stated below. Keep this information available for substitute teachers. Please contact me if you have nay questions.

**Medical Diagnosis / Condition:** Sickle Cell Anemia / Sickle Cell Trait

Sickle Cell Anemia is a congenital anemia that results from a defective molecule that causes red blood cells to roughen and become sickle-shaped. These sickle-shaped cells impair circulation, resulting in chronic fatigue, difficulty breathing on exertion, swollen joints, and premature death.

**Signs / Symptoms:**

Symptoms may be brought about by infection, stress, dehydration, strenuous exercise, and cold.

- |                         |                           |
|-------------------------|---------------------------|
| 1. rapid heart beat     | 6. chest pain             |
| 2. chronic fatigue      | 7. aching bones           |
| 3. difficulty breathing | 8. aching muscles         |
| 4. jaundice             | 9. joint swelling         |
| 5. pallor               | 10. severe abdominal pain |

**Action:**

- In the event of chest pain, shortness of breath, or blue color to the lips and mouth area, sleepiness, and/or difficulty awakening, if student is able, send him/her to the office accompanied by a teacher or responsible student.  
CALL:
  - 9-1-1
  - parent/guardian
  - school health services
- If severe pain occurs, contact parent/guardian. While you wait, apply warm compresses to painful areas and cover the child with a blanket. (Never use cold compresses, since this aggravates the condition.)
- During periods of activity, encourage fluid intake.

**Individual Consideration:**

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Parent/Guardian \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Physician \_\_\_\_\_ Phone \_\_\_\_\_ Hospital \_\_\_\_\_

Other Contact Person \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

## SORE THROAT

Date \_\_\_\_\_

Dear Parent/Guardian:

-----



# FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

520 Fifth Ave. Fairbanks, Alaska 99701-4756 (907) 452-2000

---

\_\_\_\_\_ was seen by the school nurse for a sore throat. Here are some things that you can do at home to help your child feel better.

- \* **Have you child drink at least 8 glasses of clear liquids like fruit juices and water. Sipping warm broth can also soothe the throat.**
- \* **For the relief of headache, sore throat, and/or fever, you may use a nonaspirin product such as Tylenol.**
- \* **DO NOT USE ASPIRIN.**
- \* **Sucking on sugar-free hard candy can help keep the throat moist.**
- \* **See your doctor if your child does not seem better in a few days or if the fever increases.**
- \* **Nurse comments:** \_\_\_\_\_

\_\_\_\_\_  
School Nurse

\_\_\_\_\_  
Phone

**Healthy Children Learn Better!**  
*Fairbanks North Star Borough School District nurses are doing their part.  
Thank you for doing yours.*

Revised: November 2003

## STAFF AUTHORIZATION TO DISPENSE MEDICATION Field Trips

**I knowingly give permission for the Fairbanks North Star Borough School District designated staff member to dispense medication to my son/daughter on the days the school nurse is out of the building.**

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# FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

520 Fifth Ave. Fairbanks, Alaska 99701-4756 (907) 452-2000

**Child** \_\_\_\_\_ **Grade** \_\_\_\_\_

**Staff Member** \_\_\_\_\_

**Medication** \_\_\_\_\_

**Dosage and Time of Administration** \_\_\_\_\_

### STATEMENT OF PARENT/GUARDIAN

As parent / guardian (circle one) of the above-named student, I do hereby request the Fairbanks North Star Borough School District give medication to the above-named student. I understand that the school district is not legally obligated to administer medication to the student, and in the absence of the school nurse, other school personnel will administer the medication. I agree not to institute suit against the school district for administration or nonadministration of the medication, to defend and hold the school district harmless from any liability resulting from the administration or nonadministration of the medication, and to defend and indemnify the school district and its employees from any liability arising out of this agreement. I will notify the school principal immediately if the medication is changed.

**Parent/Guardian Signature** \_\_\_\_\_

**Address** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Contact Person** \_\_\_\_\_ **Emergency Phone** \_\_\_\_\_

Please send medication in the original prescription container, and send only the amount needed for the duration of the field trip.







---

## Standing Orders For Medication Administration

The Fairbanks North Star Borough School District nurses are authorized to give the following:

**Epinephrine**, intramuscular, in appropriate doses according to the Emergency Care Medications Standing Orders Section, when in their professional judgment it is required for emergency treatment of a life-threatening allergic reaction.

**Benadryl** may be given orally at the school nurse's discretion for condition such as hives or other allergic reaction, in appropriate doses, according to the Emergency Care Medications Standing Orders Section.

**Acetaminophen** products (i.e., Tylenol) in liquid, chewable, and/or pill form to students/staff in weight/age appropriate doses for fever, pain, or discomfort with written or telephone permission of the parent/guardian for students per Administrative Reg. 1062.2.

Children's Tylenol Chewable: (each tablet contains Acetaminophen 80 mg)

Age/Weight		Dosage
2 - 3 years	(24 - 35 lbs.)	2 tabs
4 - 5 years	(36 - 47 lbs.)	3 tabs
6 - 8 years	(48 - 59 lbs.)	4 tabs
9 - 10 years	(60 - 71 lbs.)	5 tabs
11 years	(72 - 95 lbs.)	6 tabs

Children's Tylenol Elixir/Suspension: (Each 5cc (tsp) contains Acetaminophen 160 mg)

Age/Weight		Dosage
2 - 3 years	(24 - 35 lbs.)	1 tsp
4 - 5 years	(36 - 47 lbs.)	1.5 tsp
6 - 8 years	(48 - 59 lbs.)	2 tsp
9 - 10 years	(60 - 71 lbs.)	2.5 tsp
11 years	(72 - 95 lbs.)	3 tsp

For other Acetaminophen products, give as directed on the manufacturer's label.

**Chewable Antacids** (Altoid peppermints – use first; Tums – second) 1 or 2 as needed for heartburn/stomach upset.

**Herbal Cough Drops** are given at the nurse's discretion.

**Ibuprofen** products (e.g., Advil) in liquid and/or pill form to students/staff in weight/age appropriate doses for fever, pain, or discomfort with written or telephone permission of the parent/guardian for students 17 years old and under. **DO NOT TAKE THIS PRODUCT IF ALLERGIC TO ASPIRIN.**



# FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

520 Fifth Ave. Fairbanks, Alaska 99701-4756 (907) 452-2000

Children's Advil Oral Suspension: (each 5 cc (tsp) contains Ibuprofen 100 mg)  
If possible use weight to dose, otherwise age.

<b>Weight (lbs.)</b>	<b>Age (yrs.)</b>	<b>Dose (tsp)</b>
Under 24	Under 2	Consult a doctor
24 – 35	2 – 3	1 tsp
36 – 47	4 – 5	1.5 tsp
48 – 59	6 – 8	2 tsp
60 – 71	9 – 10	2.5 tsp
72 – 95	11	3 tsp

Junior Strength Advil Tablets: (each tablet contains Ibuprofen 100 mgm)  
If possible use weight to dose, otherwise age.

<b>Weight (lbs.)</b>	<b>Age (yrs.)</b>	<b>Dose (tablets)</b>
Under 48	Under 6	Consult a doctor
48 – 71	6 – 10	2 tablets
72 – 95	11	3 tablets

*For other Ibuprofen products, give as directed on the manufacturer's label.*

**Immunizations** given to students and/or school district staff at school. Written permission of parent/guardian must be obtained for students 17 years old and under. Verbal consent is acceptable with nurse completing consent form with parent's name and date.

**Flu vaccine** given to the school district staff, preferably drawn up and administered with a 25 – 27 gauge, 1 – 1 1/2 inch needle.

**Tuberculin testing** is done in accordance with the Alaska State regulations.

Standing orders reviewed and approved by:

\_\_\_\_\_  
Dr. Alice Antonescu  
FNSBSD Medical Advisor

\_\_\_\_\_  
Date



# FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

520 Fifth Ave. Fairbanks, Alaska 99701-4756 (907) 452-2000



## TETANUS/DIPHTHERIA BOOSTER

Date \_\_\_\_\_

Dear Parent/Guardian:

The last recorded tetanus/diphtheria (Td) immunization for \_\_\_\_\_ was \_\_\_\_\_ . Ten years have elapsed since the last one. Your child is now due for a Td booster. If your child had one recently, please send or FAX verification so the date can be entered in the school health record.

If not, immunizations may be obtained at the Chief Andrew Isaac Health Center, Fairbanks Regional Public Health Center, or at your medical care provider.

Military dependents may get a Td booster at Bassett Army Community Hospital or Eielson Air Force Base Clinic.

Call me at \_\_\_\_\_ if you have any questions.

\_\_\_\_\_  
School Nurse

\_\_\_\_\_  
FAX



# FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

520 Fifth Ave. Fairbanks, Alaska 99701-4756 (907) 452-2000

## TRACHEOSTOMY(Individual Health Care Plan)

### Confidential

FOR \_\_\_\_\_ DOB \_\_\_\_\_

Written on \_\_\_\_\_ by \_\_\_\_\_, RN Phone \_\_\_\_\_

\_\_\_\_\_ has a health condition you as his/her teacher needs to be aware. The description of this problem, as well as emergency care and individual considerations are stated below. Keep this information available for substitute teachers. Please contact me if you have any questions.

#### **Medical Diagnosis / Condition:** Tracheostomy / Possible Respiratory Distress

A tracheostomy (trach) is a surgical opening into the windpipe (trachea) in the neck, that is created for student who is unable to breathe through the normal air passage. The trach allows air to go in and out of the lungs. The opening in the neck is called a stoma. A metal or plastic tube, called a tracheostomy tube, may be inserted through the stoma into the trachea. If present, the tube is secured with twill tape tied around the student's neck. The trach tube/stoma may or may not be covered.

Students with tracheostomies can attend regular classrooms. Some students can manage their own trach care, but others may need to be accompanied by a trained caregiver at all times while in the educational setting or during transport. Many students with trachs participate in regular school activities, with modifications that are determined by parents and doctor. Students with tracheostomies should avoid areas with a lot of dust or other airborne particles such as chalk dust. This is because the air the student breathes the lungs directly, without being filtered, moistened, and warmed by the nose and mouth. School personnel should be able to recognize the sighs of breathing difficulty and immediately know how to assist the student with a trach.

#### **Signs / Symptoms:**

1. bluish or unusually pale skin color
2. drowsiness, unconsciousness
3. labored breathing
4. inability to move air through trach
5. flared nostrils

#### **Action:**

1. DO NOT leave student alone.
2. Call for assistance and delegate call to 9-1-1.
3. If student is unable to breath and worsening:
  - a. cut ties and remove trach tube
  - b. observe student's respiratory status
  - c. If student is breathing:
    1. stay with student offering reassurance
    2. continue monitoring
  - d. If student is blue and/or in severe distress:
    1. attempt MOUTH-TO-STOMA ventilation
    2. If MOUTH-TO-STOMA is unsuccessful, attempt MOUTH-TO-MOUTH occluding stoma with finger.

#### **Individual Consideration:**

\_\_\_\_\_  
\_\_\_\_\_



# FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

520 Fifth Ave. Fairbanks, Alaska 99701-4756 (907) 452-2000

Fairbanks North Star Borough School District



Student's Name: \_\_\_\_\_

Parent/Guardian \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Physician \_\_\_\_\_ Phone \_\_\_\_\_ Hospital \_\_\_\_\_

Other Contact Person \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Revised: November 2003



# FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

520 Fifth Ave. Fairbanks, Alaska 99701-4756 (907) 452-2000



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# FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

520 Fifth Ave. Fairbanks, Alaska 99701-4756 (907) 452-2000



## Fairbanks North Star Borough School District Release/Exchange of Information and Records Consent Form

Agency or Individual \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone Number (Optional) \_\_\_\_\_ Fax Number (Optional) \_\_\_\_\_

I give my permission and consent for the above named agency or individual to release immunization information to any clinic, hospital, medical facility, public health department or school medical department. This information may be exchanged with other health providers including state health department computerized immunization records.

Name of patient/child \_\_\_\_\_

DOB of child/patient \_\_\_\_\_

Signature of patient or parent/guardian if child is a minor:

\_\_\_\_\_

Date Signed \_\_\_\_\_

Duration of permission: \_\_\_\_\_ 1 year or \_\_\_\_\_ until revoked in writing by signer.



# FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

520 Fifth Ave. Fairbanks, Alaska 99701-4756 (907) 452-2000

Student's Name: \_\_\_\_\_ ID# \_\_\_\_\_ Date of birth \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_ Teacher \_\_\_\_\_

Date of Original Plan \_\_\_\_\_ Updated \_\_\_\_\_

## **Parent/Guardian Responsibilities** **Diabetes Care Plan**

1. The parent will work with the school nurse to establish a written care plan following the school district format. The plan will be updated each year and whenever changes occur.
2. The parent will obtain orders as appropriate for medication administration at school to include:
  - Orders for insulin at school
  - Orders for treating hypoglycemia and glucagon injection if indicated
  - Orders for testing for ketones and treatment of ketones when present
  - Orders for the student to self-administer insulin via injection or pump
3. The parent will provide the phone numbers of appropriate individuals for emergencies and routine care.
4. The parent will provide all equipment and medication to carry out the orders provided by the physician and the instructions developed in this plan. The parent will be responsible for maintaining equipment and providing additional supplies as needed.
5. The parent will provide the school with snack foods and sources of fast sugar, as well as glucagon emergency kits if ordered.
6. The parent will provide a recent photo of the student for emergency identification and encourage the student to wear medic alert identification.
7. The parent will provide a trained adult presence on any trips away from the school setting to administer glucagon injection if it is ordered. This person may be another parent, adult friend, or staff member but will be a volunteer, recruited and trained by the parent. The parent may also choose to provide this coverage.
8. The parent will keep the school informed of changes and concerns related to the student and his or her diabetes.

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Principal Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Nurse's Signature

\_\_\_\_\_  
Date





**School Responsibilities**

**Diabetes Care Plan**

1. The school nurse will work with the parent and physician to establish a written care plan following the district format. The plan will be updated each year and whenever changes occur.
2. The nurse will carry out orders received from the physician regarding all aspects of care administering or supervising blood sugar checks and insulin injections depending on the abilities of the student.
3. The nurse will communicate with the parent to keep the plan current and to pass on concerns that occur during the school day or patterns of symptoms that may be occurring.
4. The nurse will provide a safe, private area for the student to attend to routine activities associated with his or her diabetes. This area will include storage space for equipment and supplies if needed.
5. The nurse will distribute snack items to areas where the student has quick access and inform the student of these locations.
6. Two or more staff members who have regular contact with the student will have in depth instruction to include signs and symptoms of hypoglycemia, basic daily routines, and signs and symptoms of hyperglycemia.
7. A staff member who has received in-depth instruction will be present on any trips away from the school. This will include assisting the student to complete the daily routine care and contacting the nurse by phone when needed. Unless this person is a licensed medical provider, they will not be responsible for administering glucagon unless they have volunteered for this duty and have been trained by the parent of the student.
8. The school nurse will assure that staff members understand the basic facts of diabetes including symptoms of hypo and hyper glycemia as well as the needs of a diabetic student to include but not limited to the following:
  - Access to blood glucose monitoring equipment/other supplies as needed
  - Access to snack or food items whenever needed
  - Access to the nurse whenever needed
  - Access to bathroom use and fluid intake whenever needed
  - Access to staff members specially trained to assist the student

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Principal Signature

\_\_\_\_\_  
Date



# FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

520 Fifth Ave. Fairbanks, Alaska 99701-4756 (907) 452-2000

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Nurse Signature

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Date