CAMPBELL COUNTY SCHOOLS

HEALTH SERVICES

Diana Taylor RN	101 Orchard Ln.	(859) 635-2173
Health Services Coordinator	Alexandria, KY 41001	Ext: 1008

Dear Parent/Guardian

In preparation for the upcoming school year, it is important that we have accurate information/authorization to meet the medical needs of your child in the school setting.

Please have your child's physician complete the information on the enclosed forms prior to the beginning of the new school year. This information will be used to develop an Individual Health Care Plan for your child in the school setting. Medications/procedures will not be administered until all forms are properly completed and the parent/guardian provides medications and all supplies required.

If your child has Type 1 Diabetes, Children's Hospital now provides a school packet containing all information required for school attendance for those students managed through their clinic. Usually these are given to the parent/student during the summer appointment. If you did not receive this packet, please contact them now and request a completed packet.

After July 25, please contact the principal of the school your child will attend to set a time to meet with appropriate staff. If you have further questions, please contact me at (859)635-2173 ext 1008.

Thank you in advance for your cooperation. With your help we can insure a smooth transition for your child into the new school year.

Sincerely

Diana Taylor RN BSN
Health Services Coordinator
Campbell County Schools

CAMPBELL COUNTY SCHOOLS
MEDICAL STATEMENT OF HEALTH IMPAIRMENT

Student_____ DOB_____

TO BE COMPLETED BY A LICENSED PHYSICIAN IN ORDER TO VERYIFY THE EXISTENCE OF A HEALTH IMPAIRMENT WHICH MAY ADVERSELY AFFECT A STUDENT'S INSTRUCTIONAL TOLERANCE AND ACADEMIC PERFORMANCE AND QUALIFY THE STUDENT FOR RESONABLE ACCOMODATIONS AND/OR SPECIAL EDUCATION AND RELATED SERVICES.

1. Diagnosis and nature of health impairment:

2. The effect of the impairment upon the vitality, strength, or alertness of the student:

3. Recommended treatment and the effect of the treatment upon the vitality, strength, or alertness of the student:

4. Suggestions for educational interventions, physical restrictions, or other comments regarding the student's functioning in an educational setting:

PHYSICIAN'S SIGNATURE_____ DATE_____

Physician's name address, and phone number (typed or stamped)

Return completed form to:

I hereby authorize the release of the above information by the student's physician to school officials for their use in any educational, rehabilitation, health, statistical, or informational purposes. It is understood that this information will remain confidential and will become part of the student's educational record.

Parent/Guardian Signature_____ Date_____

CAMPBELL COUNTY SCHOOLS
AUTHORIZATION FOR TREATMENT

Dear Parent(s) and/or Guardian:

If your child requires a specific health related treatment or procedure done at school, we need to have the following information, as well as signed permission from you and your child's physician. The purpose of this is to make sure your child gets the required treatment or procedure as ordered.

Student's name_____

Duration of this form:_____school year or until the treatment has changed.

Describe the treatment procedure in detail and include any specific instructions:

_____

Times to be
Administered:_____

During the school hours of _____and _____ it is my understanding that the school nurse and/or trained school personnel will administer the prescribed treatment or procedure according to the above instruction of the physician.

Sincerely,

Principal or Director/Nurse

_____

Authorized Signatures

_____ _____ _____ _____
Parent Date Physician Date

_____
Physician's Address City/State Zip Telephone Number

I do hereby give permission for a mutual exchange of medical information of the above named student between the physician that authorized this procedure and a designated representative of Campbell County Schools.

Signature of Parent/Guardian_____ Date_____

CAMPBELL COUNTY SCHOOLS
CONSENT FORM FOR ADMINISTERING MEDICATION AT SCHOOL

Student's Name_____ Grade_____

Name of Medication_____

Dosage_____

Time(s) To Be Given_____

Diagnosis Or Reason For The Medication To Be Given_____

Possible Side Effects:_____

Student's Allergies:_____

Name of Prescribing Doctor_____

_____ _____
Signature of Prescribing Doctor Date

****

I request my child be permitted to take medications as outlined above and expressly waiver any liability on behalf of the school as a result of administration of the above drug(s) and do hereby give permission for a mutual exchange of medical information between the physician that authorized this medication and a designated representative of Campbell County Schools.

_____ _____
Signature of Parent/Guardian Date

_____
Name of School Submitted to

Campbell County Schools Health Services

Administration of Medication at School

Since it is recognized that some students are able to attend school because of the effectiveness of medications in the treatment of chronic disabilities and illnesses, this procedure has been adopted to help insure safe administration of medications in school.

A. No medication, prescription or over-the-counter, may be administered to students by an employee of the Campbell County Board of Education unless the **Consent Form for Administering Medications at School** form is filled out and signed by both the physician and parent/guardian. No handwritten notes by parent/guardian will be accepted.

B. Only doses of medication that cannot be administered at home will be given at school. Medication will not be administered at school due to convenience.

C. Any student who is required to take medication during regular school hours shall comply with the following:

1. No medication will be supplied by the school.
2. Prescription medications shall be brought to school in the original container that is properly labeled with the following information:
    a. Name of student
    b. Name of medication
    c. Dosage of Medication
    d. Time medication is to be administered
3. Nonprescription medication must be brought to school in original container and will only be administered with a physician signature on the appropriate Campbell County Schools Medication Consent form.
4. No medication, prescription or nonprescription, may be transported by the student on the school bus.
5. Medications should be provided in the form that it is to be administered. School staff will not divide tablets, etc.
6. School staff will not administer the first dose of any newly prescribed medication.
7. All medication will be kept in the school office in a specified safe place. Students are not permitted to have medication in their possession.
8. Self-managed/self-carry administration of emergency medication (insulin, inhalers, Epi-Pens) will be permitted with written authorization of parent and physician on the appropriate Campbell County Schools Self-Carry form.
9. It is the student's responsibility to comply with the doctor's order concerning administration of medications. Upon receipt of the signed consent form, school personnel will endeavor to assist students with medications.
10. All prescription medication amounts will be verified by nurse and parent/guardian upon initial arrival to office.
11. Every dose of medication administered by school personnel shall be recorded on a prescribed form.
12. Medications that contain narcotics or sedation for pain will NOT be administered at school to help Insure student safety.

******School personnel responsible for administration of medications will refuse to administer medication if the above guidelines are not followed. In such situations, the parent/guardian will be notified.*******

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
CAMPBELL COUNTY SCHOOLS

STUDENTS FULL NAME_____DATE OF BIRTH_____

Address_____Social Security Number_____

_____

Specific type of information being requested:
____History and Physical
____Educational Evaluations
____Speech/Language Evaluation
____Occupational Therapy/Physical Therapy Evaluations
____School Recommendations
____Medical Information that Impacts School Performance (including medications)
____Other
____Other
____Other

This information indicated above shall be disclosed to:

Name_____ Name_____

Agency/School_____ Agency/School_____

Title_____ Title_____

Address_____ Address_____

_____ _____

This authorization will be valid for the _____school year and may be revoked, in writing, at any time by parent/guardian. It is understood that information disclosed/action taken prior to the revocation cannot be reversed. Any information disclosed will become part of the student's permanent school record.

I,_____, parent/guardian of student named above, authorize the release of the information indicated above by:

Name/Organization: _____

Address: _____

_____

Phone: _____

To the representative(s) of Campbell County Schools.

Signature_____ Date _____

____Parent ___Legal Guardian ____Student

Witness _____ Date _____