LYON COUNTY SCHOOL DISTRICT
BOARD POLICY _____JC

Medication in Schools

Lyon County School District prohibits the administration of any medication to students in grades Pre-kindergarten through 6, prescriptive or non-prescriptive, without written permission of the physician, parent/guardian, and the registered or licensed practical nurse employed by LCSD. Non-prescriptive medications include, but are not limited to, aspirin, acetaminophen, ibuprofen, cough syrup, and other medicinal health aides available for purchase over the counter without age or identification requirements. Students in grades 7-12 are permitted to carry and self-administer over-the-counter medications according to the dosage recommendations.

Pursuant to SB 453, Lyon County School District will provide undesignated auto-injectible epinephrine to any student on an LCSD campus during regular school hours who the school nurse or trained/qualified employee reasonably believes is experiencing anaphalaxis. Undesignated epinephrine will be administered according to the standing order obtained annually.

Students may carry and/or self-adminster asthma inhalers, insulin, glucagon and Epi Pens with a completed “consent and request for medication during the school day” where both Authorized Medical or Health Care Provider and parent/guardian have in writing stated the student may carry and self-adminster.

District administration shall establish administrative regulations, which comply with the Nevada Nurse Practice Act NRS 632, NAC 632, governing the request for and administration of medications and medicines by District personnel. Requirements contained in these regulations shall provide for the health, safety, and well-being of all students, and shall relieve the Lyon County School District, its Board of Trustees, and all agents and employees of the District from any liability for the administration of any requested medication authorized by a licensed prescriber (NRS Chapters 453, 454, or 639) or from students in grades 7-12 self-administering.

Reference: NRS 632, NAC 632, NRS 453, 454, 639, and SB 453

PROCEDURE FOR THE ADMINISTRATION AND RECORDING OF MEDICATION

MEDICATION IN SCHOOLS

If it becomes necessary for a student to take medication during the school day, there are two options:

- The parent may come to school and administer the medication to the child, or
- The school health care staff, or in their absence, a "qualified person" as defined by NAC 632.226 will administer the medication or help the student to self-administer the medication. All medication will be administered in a manner that protects the privacy rights of the student, or
- The school health staff and district Chief Nurse retain the right and discretion to refuse any request for administration of medications.

Prescription Medication

In order to administer prescription medication, the following requirements must be met:

- The medication must have been prescribed by a licensed physician or licensed practitioner.
- LCSD Form 131 must be properly completed and signed by the parent or legal guardian, the prescribing physician, and a registered or licensed practical nurse employed by LCSD.

    a. An order signed by the prescribing physician may be attached to the form in lieu of his/her signature.

    b. The school health care staff at their discretion, may use a current pharmacy labeled container as written physician permission.

- The medication must be contained in a pharmacy-labeled container.
- Controlled substance medications must be brought to school by a parent or responsible adult.

Procedure for the Administration and Recording of Medication

Non-Prescription (Over-the-Counter) Medication

Students in grades 7-12 are permitted to carry and self-administer nonprescription (over-the-counter) medication that are available for purchase without identification requirements. However, this privilege may be rescinded if abuse occurs. Abuses will be dealt with on an individual basis according to the progressive discipline plan, reviewed by an administrator and the school's health care staff.

In order to administer non-prescription medication to students in grades Pre-kindergarten through 6, the following requirements must be met:

1. LCSD Form 131 must be properly completed and signed by the physician, parent/legal guardian and the registered or licensed practical nurse employed by LCSD.

2. The medication must be in its original container.

STUDENTS

Asthma Rescue Inhalers, Epinephrine Auto-Injectors, Glucagon and Insulin

The parent/legal guardian of a pupil who has diabetes, asthma and/or anaphylaxis may request permission for their child to carry and self-administer insulin, asthma rescue inhalers, glucagon and/or epinephrine auto-injectors. LCSD Form 159 must be properly completed and signed by the parent/legal guardian, prescribing physician, and the registered or licensed practical nurse employed by LCSD (NRS 392.425). Asthma rescue inhalers, Epinephrine auto-injectors, and glucagon may be administered by trained staff in emergency situations per NRS 632.222 and NRS 453.

Storage of Medication

Emergency medication such as epinephrine and asthma inhalers will be stored in an unlocked area out of the reach of students. All other medication that is stored on school premises must be kept in a locked cabinet in the health office. With the exception of high school and middle school students who may carry non-prescriptive medications and students at any grade level who have asthma rescue inhalers, glucagon or epinephrine auto-injector permission, no medication may be kept on his/her person, in their locker, backpack, or in the classroom. However, certain health conditions may warrant an exception by the school's health care staff. These exceptions will be documented and approved by the area Registered Nurse or the Chief Nurse. Parents/Guardians will be contacted near the end of each school year to retrieve unused medication. Medication that is not retreived at the end of each school year will be destroyed.

Medication Administration Delegation

Only the school health care staff, or appropriately trained "qualified person", may administer medication. Medication delegation will be done in accordance with the Nevada Nurse Practice Act NRS 632, NAC 632 and documented on LCSD Form 162.

Procedure for the Administration and Recording of Medication

All requests from parents/guardians for medication administration must be referred to the school health care staff. Teachers and other school staff will not accept requests to administer medication from parents independently of the school health care staff.

Documentation of Administration of Medication

The school health care staff will use the Infinite Campus and/or Medication Administration Record to keep a record of all medications administered at school. Student response to the medication is monitored jointly by the school health care staff and the student's teacher. Adverse responses are documented by the school health care staff in the student's health record and communicated to the parent/guardian.

Controlled Substance Inventory

Controlled substances must be counted daily and documented in the Infinite Campus Medication Administration Record. This record and or form includes current count, addition, return, and waste. The school health care staff is responsible for the maintenance of this record and may perform the daily count alone. Controlled substance addition, return, and waste require a second witness signature. The District Chief Nurse and Site Administrator must be notified if discrepancies occur.

Medication Error

If a medication error occurs, LCSD Form 175 must be completed and the District Chief Nurse and Site Administrator notified. The student's prescribing health care provider and parent/guardian must be contacted to discuss potential adverse reactions.

Designation and Traning of a “Qualified Person”

School Nurse will train each “Qualified Person” annually in correct medication administration. Qualified persons will be trained to follow the 6 Rights of Medication Administration:

1. Right Student
2. Right Medication/Drug
3. Right Dosage
4. Right Route
5. Right Time
6. Right Documentation.

Additional training to include:

- Avoid touching the student's tablets or capsules by shaking the appropriate dose into a disposable cup or the medication lid and then having the student self-administer the medication.
- Always return the medication to the locked cabinet or drawer immediately after administering the medication.
- Keep the keys to the medication drawer in a location that is not accessible to students.
- Have students wash their hands before touching their medication.

If the medication is in liquid form:

- Refrigerate per label instructions
- Pour the medication from the side of the bottle opposite the prescription label (hold label in palm of hand)
- Use a parent-provided graduated medicine syringe or cup for liquid medicines
- Measure the dosage of eye level, ensuring that the surface of the medication is level with the correct dosage marking on the medicine syringe or cup
- Wipe off any medication on the outside of the container.

NOTE: For medications that are ordered for other than the oral route, the school nurse will provide specific training for the school health aides and other UAP's to ensure standard administration techniques for these medication routes.

LYON COUNTY SCHOOL DISTRICT
HEALTH SERVICES
ASTHMA/ALLERGIES QUESTIONNAIRE

Student:_____ DOB: _____

Dear Parent/Guardian:

Your child's health record states that he/she has either asthma or allergies. Since we want to protect your child's health and well-being while in school, it is necessary for us to have more complete, specific information. Please complete the section below as soon as possible to the health office at your school.

If our records are incorrect or your child has outgrown the condition, please let us know. We will make sure the health record is corrected. Please feel free to call me if you wish to discuss your child's health status. Thank you.

ASTHMA

1. Check Appropriate Space:

   ☐ Mild: Seldom has an attack. Does not need medication.
   ☐ Moderate: Occasional attacks. Medication for attacks only.
   ☐ Severe: Frequent attacks. Requires medication every day.
   Name of Medication: _____

2. Check Appropriate Space:
   ☐ My child does NOT require medication to be kept at school.
   ☐ I want medication kept at school in case of an attack (*see below).
   ☐ I want to be called if my child has an attack at school.
   ☐ Asthma occurs at all times of the year.
   ☐ Asthma only occurs in the_____.
   ☐ There is not limitation on activity.
   Please state any limitation to physical activity or education: _____

ALLERGIES

My child is allergic to the following substances. Please list and explain: _____

_____

*PLEASE NOTE: The Health Care Staff is not permitted to give any medication to your child without a written consent from you and your physician. All medications, including inhalers must be brought to school by an adult with a completed "Consent and Request for Medication during the School Day" (LCSD Form 131)

Parent Signature:_____ Date: _____

LYON COUNTY SCHOOL DISTRICT
HEALTH SERVICES

REQUEST FOR MEDICATION DURING SCHOOL DAY

The prescribing physician advises you that _____,
(Student Name)
_____, a certified student of the Lyon County School District, attending _____
(Birthdate) (School)
requires the following medication during the school day:

Name of medication: _____
Dosage of medication: _____
Route of medication: _____
Time medication is to be given: _____

For school year: _____ Date to start: _____ Date to end: _____

This medication will be provided to the Lyon County School District by the student's parent/guardian and the undersigned parent/guardian agrees to assume all responsibility for maintaining the supply of the medication and replacing such medication when its effectiveness has lapsed/expired.

The undersigned parent/guardian hereby requests the Lyon County School District, through Special Services or school staff, to administer the above-described medication as set forth and further consents to the administration of such medication during the school day. The undersigned parent/guardian hereby expressly relieves the Lyon County School District, its Board of Trustees, and all agents of the District from any liability for the administration of such medication.

_____ _____
Signature of Prescribing Physician Phone Date

_____ _____
Signature of Parent/Guardian Date

REVIEWED BY:

_____ _____
Registered Nurse/Licensed Practical Nurse Date

Lyon County School District
CONTROLLED SUBSTANCE INVENTORY RECORD

School Year: _____ School: _____
Student: _____ DOB: _____
Medication: _____

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
August																															
September																															
October																															
November																															
December																															
February																															
March																															
April																															
May																															
June																															

At the end of each day, document the number of tablets you will starting with the next day.

Initials: _____ Signature: _____ Printed Name: _____

LYON COUNTY SCHOOL DISTRICT
HEALTH SERVICES
NOTICE OF DENTAL INSPECTION

Date: _____

Dear Parent(s)/Guardian(s):

A dental inspection of your child,_____, has been made at school.

The results of this dental inspection indicate:

- ⎦ Need for dental attention. It is recommended that your family dentist be consulted as soon as possible.
- ⎦ No readily apparent dental caries (cavities). However, it is recommended that your child visits your family dentist regularly.
- ⎦ No apparent problem. Keep up the good work!

Many people neglect primary teeth because they know the primary teeth will be lost eventually. It is important to realize the primary teeth play a crucial role in the proper development of a child's permanent teeth.

Please feel free to contact me if you have any questions.

Sincerely,

Phone: _____

LYON COUNTY SCHOOL DISTRICT
HEALTH SERVICES
LICENSED HEALTH CARE PROVIDER'S DIABETIC ORDERS
CONFIDENTIAL

1. Student's Name:_____ DOB: _____
2. ☐ **Student will independently manage his/her diabetes:** ***no need to complete items 3-8.***

Please sign box at the bottom of the page.

3. Name of treatments or procedures:
   _____Blood Glucose Monitoring
   _____Insulin Administration: ☐ Pen ☐ Pump ☐ Injection
   _____Ketone Testing
4. While at school, blood glucose monitoring is to be done:
   _____Before Lunch
   _____Before PE
   _____When Symptomatic
   _____Other (Please Specify): _____
5. Snacks:
   _____Give daily snack at the following times _____ _____ _____ _____ _____
   _____No routine daily snacks required at school.
6. **Hypoglycemia (Low Blood Sugar):** **Individual Considerations:**
   If blood sugar is less than_____(or less than 100 and Symptomatic): Give _____
   - Recheck blood sugar in 10-15 minutes. _____

   If blood sugar is still less than_____ Give _____
   - Recheck blood sugar in 10-15 minutes: _____
   - If next scheduled meal is greater than 30 minutes away: _____

   If blood sugar is still less than_____, or if child is still symptomatic:_____
   - If acting seriously ill, call 911.
   - Call parent/guardian to pick child up from school.
7. **Hyperglycemia (High Blood Sugar):** **Individual Considerations:**
   If blood sugar is greater than _____ _____
   - Check urine for ketones. _____
   - Encourage non-caloric fluids (water, diet drinks) _____

   If ketones "negative or trace": _____
   - Recheck blood sugar in 2-3 hours. _____

   If ketones "moderate or large": _____
   - Contact parent/guardian to pick child up from school. _____
   - Encourage parent/guardian to call doctor. _____
8. Routine Management/Correction Factor at School: _____
   _____
9. Additional Instructions: _____
   _____
   _____

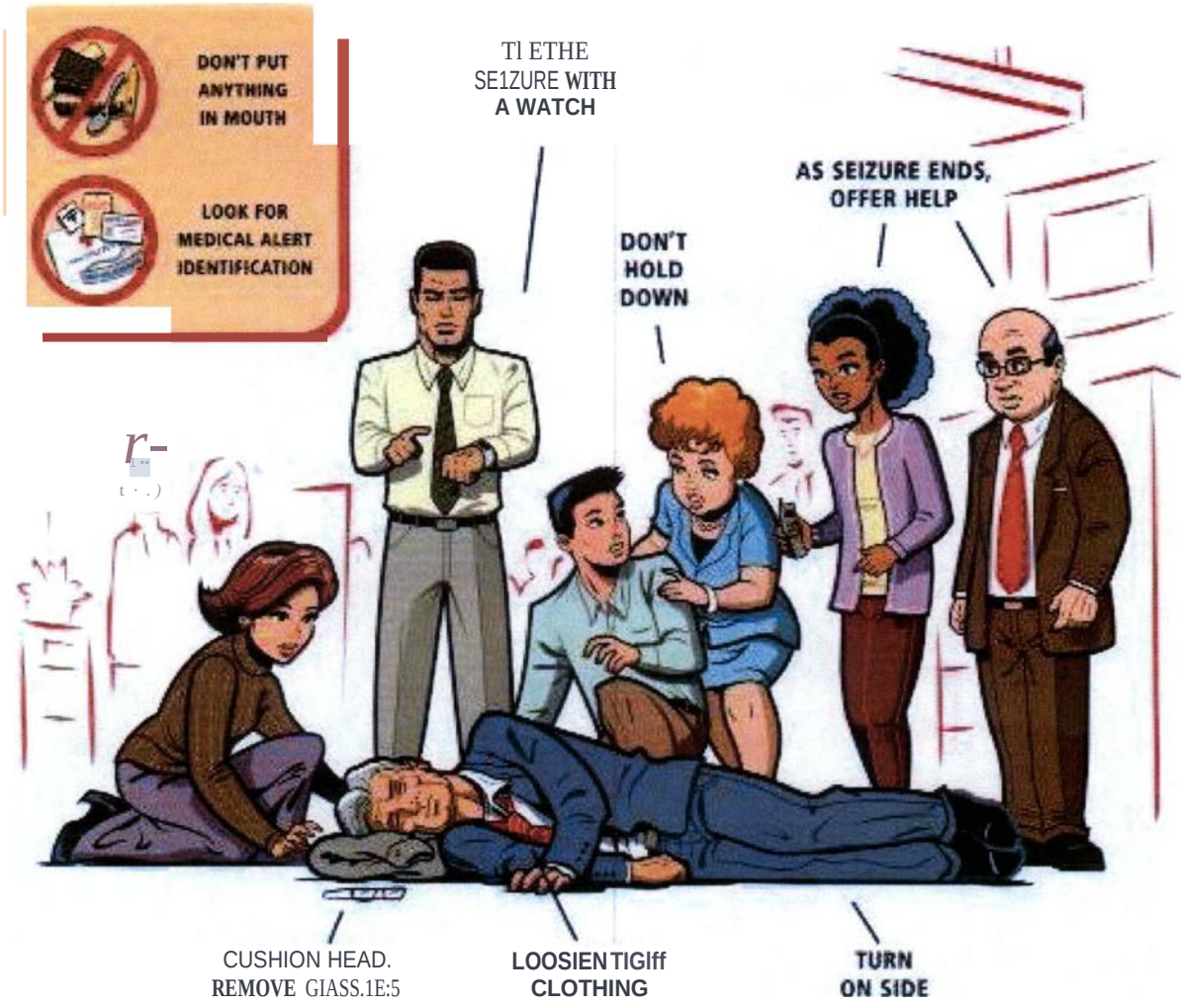
Name of Health Care Provider (Please Print): _____

Health Care Provider Signature: _____

Date:_____

First Aid for Seizures

(Convulsive, generalized tonic-clonic, grand mal)



Most seizures in people with epilepsy *are* not dkal em rg,en c.ies. They end,aft er .a min ute or two thout harm and usu.ally do not t'equ ire a trip to he @me QffiCY 1 room.

au ornetimes th e rI! are 900d ri asons to ca[foremergency help. A seizure in sorneorie who does net have epi epsy cauld be .*a* sign of **a** se r1ov1 cUness.

0 her :rettsons to ca ll .in ambulance irtd **de:**

A se izure that la.sts mote than 5 minut,es

NO NepHep$yN oir $e izu re disorder"

identific.at on

Slow recovery, second sel:zur . or d it fi cuJty b reat'1·ng ,af terw a.rdls

Preg mmcy or other medical diagnosis

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EPILEPSY FOUNDATION®

EPILEPSY FOUNDATION AND UCB PHARMA, INC. ARE PARTNERS IN PROVIDING PEOPLE WITH EPILEPSY AND THEIR CAREGIVERS VALU ,UU INI:JH IM 1U LATW Tllrl \T a, IONS AVAILABLE, AND PATIENT EDUCATION PROGRAMS DESIGNED TO HELP PATIENTS TAKE AN ACTIVE ROLE IN THEIR TREATMENT.

LYON COUNTY SCHOOL DISTRICT
HEALTH SERVICES
HEAD INJURY SHEET

Date: _____

Dear Parent: _____

Today, _____ received an injury to the head.

Most head injuries are minor and do not require medical attention. But some apparently minor injuries can be more serious. The amount of swelling at the site of the injury does not indicate the seriousness of the injury.

The real extent of a head injury can be determined only after careful observation for 24 hours after the injury. Some head injuries result in delayed reactions and complications.

Your child was seen in the clinic and had no problems at that time, but you should watch for any of the following symptoms:

1. One of the most important signs is the degree of mental alertness. Child should be aroused every 2 hours for the first 12 hours and be able to awaken normally. In the case of small children. Let them walk to the bathroom. If they are able to do this well, they are reasonably alert and coordinated.
2. Nausea and excessive vomiting.
3. Dizziness, child unable to balance him/herself.
4. Visual disturbance such as double vision or difficulty focusing.
5. Persistent headache or one that is increasing in intensity.
6. Changes in personality or loss of memory (confusion).
7. Seizure/convulsions.
8. Weakness of facial muscles, arms or legs or inability to use one side of the body.
9. Difference in the size of the pupils.
10. Fluid and/or bleeding from the eyes, ears or nose.
11. Do not give aspirin or any pain medication without first consulting with a physician.

CONTACT YOUR DOCTOR OR EMERGENCY ROOM IF YOU NOTICE ANY OF THE ABOVE SYMPTOMS.

Health Care Office _____

School/Phone Number _____

LYON COUNTY SCHOOL DISTRICT
HEALTH SERVICES
HEALTH SCREENING RECORD

Date of Screening: _____

Student's Name: _____ Grade: _____

HEIGHT AND WEIGHT:

Height W/O Shoes: _____ inches

Weight W/O Shoes: _____ pounds

VISION:

Right: _____

Left: _____

Both: _____

Glasses (circle one) Yes No

Contacts (circle one) Yes No

VISION:

Right: 4000 Hz _____ 2000 Hz _____ 1000 Hz _____

Left: 4000 Hz _____ 2000 Hz _____ 1000 Hz _____

Hearing Aides (circle one) Yes No

SCOLIOSIS:

Pass _____ Recheck _____ Refer _____

COMMENTS: _____

_____

_____

_____

LYON COUNTY SCHOOL DISTRICT
HEALTH SERVICES
HEALTH SERVICES LETTER

Dear Parents,

In order to control the spread of communicable diseases in the classroom, we ask your cooperation in instituting the following procedures:

1. Please do not send your child to school if he/she has:
    a. Vomited or had diarrhea in the last 24 hours.
    b. If he/she has had a fever of 99.6 degrees or higher in the past 24 hours.
        i. We must exclude the child from school for a temperature of 100 degrees or higher.
    c. If he/she has obvious severe cold symptoms.
        i. Sneezing, nasal congestion, runny nose, persistent cough or sore throat.
    d. If his/her eyes are itching, burning, bloodshot, draining or matted shut in the morning, as these can be symptoms of conjunctivitis (pink eye). Conjunctivitis is *usually* very contagious and needs treatment by your doctor.
        i. A child may return to school after a minimum of 24 hours of antibiotic eye ointment treatment.
2. Regarding injuries sustained at home, sports practice, or places other than school:
    a. If you suspect any injury, please have it checked by your physician. We are not able to assume responsibility to assess and refer for these injuries. We will cooperate with any written special instructions your physician has regarding an injury such as limited PE or special needs in the classroom.
3. Health Screenings are legally mandated by NRS and will be done throughout the school year under the direction of the Chief Nurse.
    a. Screenings will include vision, hearing, height, weight, and scoliosis.
    b. At all times the student's privacy and confidentiality will be maintained.
    c. If you have any questions or if you do not wish your child to participate in these screenings, please contact the Health Services Office at your child's school.

If you have any questions, please contact the Health Services Office at your child's school.

Health Services Office: _____

School Phone Number: _____

LYON COUNTY SCHOOL DISTRICT
HEALTH SERVICES
NOTICE OF HEARING SCREENING FAILURE

Date: _____

Dear Parent(s)/Guardian(s):

_____ Recently failed a routine hearing-screening test, exhibiting the following hear loss:

_____ Right Ear

_____ Left Ear

_____ Both

Every hearing loss must be considered a serious health risk and a real obstacle to learning and social development. Please take your child and the attached audiogram to your family physician as soon as possible for an examination.

Please advise me of his/her findings and feel free to contact me if you have any questions.

Sincerely,

Phone: _____

Quick Reference Emergency Plan

for a Student with Diabetes

Hyperglycemia
(High Blood Sugar)

Photo

Student's Name

Grade/Teacher Date of Plan

Emergency Contact Information:

Mother/Guardian			**Father/Guardian**		
Home phone	Work phone	Cell	Home phone	Work phone	Cell

School Nurse or **Diabetes Personnel** **Contact Number(s)**

Causes of Hyperglycemia

- Too much food
- Too little insulin
- Decreased activity
- Illness
- Infection
- Stress

Onset

- Over time-several hours or days

Symptoms

Mild

- Thirst
- Frequent urination
- Fatigue/sleepiness
- Increased hunger
- Blurred vision
- Weight Joss
- Stomach pains
- Flushing of skin
- Lack of concentration
- Sweet, fruity breath
- Other:_____

Circle student's usual symptoms.

Moderate

- Mild symptoms plus:
- Dry mouth
- Nausea
- Stomach cramps
- Vomiting
- Other:_____

Circle student's usual symptoms.

Severe

- Mild and moderate symptoms plus:
- Labored breathing
- Very weak
- Confused
- Unconscious

Circle student's usual symptoms.

Actions Needed

- Allow free use of the bathroom.
- Encourage student to drink water or sugar-free drinks.
- Contact the school nurse or trained diabetes personnel to check urine or administer insulin, per student's Diabetes Medical Management Plan.
- If student is nauseous, vomiting, or lethargic, call the parents/guardian or call for medical assistance if parent cannot be reached.

Excerpted from: Helping the Student with Diabetes Succeed: A Guide for School Personnel. Published by National Diabetes Education Program: A Joint Program of the National Institutes of Health and the Centers for Disease Control and Prevention

HYPERGLYCEMIA

High Blood Sugar

SIGNS AND SYMPTOMS

Drowsiness

Frequent Urge to Urinate

Extreme Thirst

Dry Mouth

Frequent Bed Wetting

Blurred vision

NovolinCare·

HYPOGLYCEMIA

Low Blood Sugar

SIGNS AND SYMPTOMS

Trembling

Dizziness

Blurred Vision

Mood Changes

Extreme Tiredness and Paleness

Hunger

Sweating

Headaches

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being there

LYON COUNTY SCHOOL DISTRICT
HEALTH SERVICES
INSECT STING SENSITIVITY

Student: _____ Date: _____

Dear Parent:

Your child's health record states that he/she is allergic to insect bites/bee stings. Since we want to protect your child's health and well-being while in school, it is necessary for us to have more complete and specific information. Please complete the section below and return it to the Health Services Office at your child's school.

If our records are incorrect or your child has outgrown their sensitivity, please let us know. Please feel free to call the Health Services Office at your child's school if you wish to discuss their health status.

1. When stung by a bee, my child has the following reaction(s):
   - ⎦ Faints
   - ⎦ Has trouble breathing
   - ⎦ Develops a headache
   - ⎦ Becomes nauseated or vomits
   - ⎦ The area that is stung becomes red and swollen
   - ⎦ Other _____
2. The length of time between the sting and the development of a reaction is usually:

   Minutes: _____ Hours: _____

3. What type of treatment does your child require when stung? _____
   _____
   _____
4. What action would you like us to take in the event that your child is stung at school and we are unable to reach you? _____
   _____
   _____

Parent Signature: _____ Date: _____

Lyon County School District
Health Services
Insulin Management Log

School Year: _____ School: _____ Teacher: _____
Student: _____ DOB: _____ Room: _____
Parent/Guardian: _____ Physician Address: _____ Phone: _____

Date	Time	Carbs Snack	Carbs Lunch	Blood Glucose Result	Ketone Result (Neg., S, M, L)	Total Insulin Correct/Ratio		Comments (Note any unusual circumstances)	Initials

Initials	Signature of Staff Providing Care	Initials	Signature of Staff Providing Care

LYON COUNTY SCHOOL DISTRICT
HEALTH SERVICES

MEDICATION ADMINISTRATION DELEGATION RECORD

School Site:_____ School Year: _____

Registered Nurse: _____

The following personnel have been trained as “qualified persons” and have the authority to administer medication(s) to a student, as prescribed under Lyon County School District Form 131 An LCSD Registered Nurse has provided the listed personnel the necessary medication training including, but not limited, to the "Six Rights" of medication administration. This form will be kept in the medication binder in each health office and upon request, copies provided to the District Chief Nurse.

Name	Position	Date

LYON COUNTY SCHOOL DISTRICT
HEALTH SERVICES

MEDICATION ADMINISTRATION DELEGATION RECORD

My signature below verifies my willingness to administer medication(s), and that I have been designated as a "qualified person". I have been instructed in the "Six Rights" of medication administration and the Lyon County School District administrative regulation concerning medication administration procedure. All my questions and concerns have been addressed and if I develop future questions or concerns, I will consult the Chief Nurse or area Registered Nurse.

School Site:_____School Year: _____

Registered Nurse: _____

Name	Position	Date

Lyon County School District

Medication Delivery Log

Student's Name: **Medication:**

Date Received	Amount Received	Nurse's Initials	Signature of Person Delivering Medication		Date Received	Amount Received	Nurse's Initials	Signature of Person Delivering Medication
Nurse's Initials/Signature					Notes:			

Count all controlled substance drugs with the person who brings them in. Please not that signatures are required.

LYON COUNTY SCHOOL DISTRICT
HEALTH SERVICES

MEDICATION ERROR REPORT

School Site: _____ Date: _____

Date Error Was Discovered: _____

Person Reporting Error: _____ Title: _____

Error Made By: _____ Title: _____

Student(s) Involved: _____

Description of Error: _____

Action Taken: _____

Resolution: _____

Signature: _____

Chief Nurse Signature: _____

This form is to be filled out immediately upon discovery of any medication error. The original is to be sent to the Director of Special Services and a copy kept by the Chief Nurse and Site Administrator. The student's physician and parent/guardian must be notified of the error.

Lyon County School District

Health Services

Medication Record - Administration of Physician's Order

School Year: _____

Student: _____

Medication, Route: _____

Date, Dose, Time: _____

Date, Dose, Time: _____

Date, Dose, Time: _____

School: _____

DOB: _____

Physician: _____

Physician Address: _____

Comments: _____

Teacher: _____

Room: _____

Phone: _____

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
August																															
September																															
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February																															
March																															
April																															
May																															
June																															

Initials	Name	Initials	Name

CODES			
-	Weekend	D	Early Dismissal
H	Holiday	W	Dose Withheld
N	None Available	O	No Show

LSCD Form 174 (11/17)

LYON COUNTY SCHOOL DISTRICT
HEALTH SERVICES
NOTICE OF REQUIRED IMMUNIZATION(S) NEEDED

In compliance with NRS 392, 435, 437, and 439 your child will need the immunizations listed to continue attendance at school.

Dates of doses already on file are listed and needed doses are highlighted.

See attached second page.

Student Name:_____ DOB:_____

Name of Parent/Guardian:_____ Phone: _____

Official immunization record must be submitted by_____or the student may be excluded from school.

Health Services Office: _____

Date: _____

LYON COUNTY SCHOOL DISTRICT
HEALTH SERVICES

PROGRESS NOTE

DATE	NOTES	INITIAL

INITIALS	SIGNATURE	PRINTED NAME

Lyon County School District
Health Services

RECORD OF MEDICATION COUNT

Date	# of Pills	Signature #1	Signature #2	Comments

DURING DROP OFF, RETURN

Lyon County School District
Health Services

RECORD OF MEDICATION COUNT

Date	# of Pills	Signature #1	Signature #2	Comments

DURING DROP OFF, RETURN, OR WASTE

LYON COUNTY SCHOOL DISTRICT
HEALTH SERVICES
RELIGIOUS EXEMPTION FROM IMMUNIZATION
(NRS 392.437-392.439)

Student Name:_____ Date:_____

School:_____ Grade: _____

As the parent or guardian of the above-named student, I submit that immunizations, which are required by law for school enrollment, are prohibited according to my religious beliefs. I therefore request that the school enroll my child under this exemption.

I understand that state law (NRS 392.446) requires either the removal or immunization of my child in the event of a dangerous contagious disease in the school where my child attends. I also understand that any parent or guardian who refuses to remove his or her child from the public school in which he or she is enrolled, when law prohibits a continued enrollment, is guilty of a misdemeanor (NRS 392.448).

Parent Signature:_____ Date: _____

LYON COUNTY SCHOOL DISTRICT
HEALTH SERVICES

REQUEST TO CARRY AND SELF ADMINISTER INSULIN, ASTHMA RESCUE INHALER AND/OR EPINEPHRINE AUTO-INJECTOR

Student Name:_____ DOB: _____

School Site:_____ School Year: _____

Name of Medication: _____

The above referenced student is responsible for carrying and capable of self-administering the above medication. He/she understands the medication purpose and appropriate method of administration.

Physician Signature:_____ Date:_____

Physician Name (Printed): _____

The undersigned parent/guardian hereby requests the Lyon County School District allow my child, to carry and self-administer: _____.

The undersigned parent/guardian hereby expressly relieves the Lyon County School District, its Board of Trustees, and all agents of the District from any liability for the self-administration of this medication.

Parent Signature:_____ Date: _____

Parent Name (Printed): _____

Reviewed By:
Nurse:_____ Date: _____

LYON COUNTY SCHOOL DISTRICT
HEALTH SERVICES

REQUEST TO CARRY AND SELF ADMINISTER INSULIN, ASTHMA RESCUE INHALER AND/OR EPINEPHRINE AUTO-INJECTOR

STUDENT, PARENT, NURSE CONTRACT

Student Name:_____ DOB: _____

School Site:_____ School Year: _____

Contract between Student, Parent and Nurse:

- Student has demonstrated to nurse correct use of medication.
- Student agrees to NEVER share the medication with another person.
- Asthma Rescue Inhaler: Student agrees that after two puffs, if there is not improvement, he/she will go to see the nurse or after hours call parent immediately.
- Epinephrine Auto-Injector: Student agrees that if administered, he/she will go to the nurse or after hours call parent immediately.

Student's Signature:_____ Date: _____

I give permission for my child_____to carry the medication described below. I understand that he/she must follow the rules listed above. I will notify the nurse of changes in medication or my child's condition.

Name of Medication	Dosage	Frequency of Use
_____	_____	_____
_____	_____	_____

Parent Signature:_____ Date: _____

Parent Name (Printed): _____

Reviewed By:
Nurse:_____ Date: _____

Lyon County School District
Health Services
SEIZURE CHART

Student: _____ DOB: _____ Location _____

NUMBER OF SEIZURES

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
August																															
September																															
October																															
November																															
December																															
February																															
March																															
April																															
May																															
June																															

Initials	Name	Initials	Name

CODES			
G	Grand Mal	F	Febrile
PM	Petit Mal	P	Psychomotor
S	Status Epilepticus		

LYON COUNTY SCHOOL DISTRICT
HEALTH SERVICES
GUIDELINES FOR SEIZURES

The teacher will be notified of any known student they have who suffers from a seizure disorder. Seizures can occur to anyone at any time. Seizures can be frightening but usually only last a few minutes.

FIRST: Call the office for help.

1. STAY CALM
    a. You cannot stop a seizure once it has started without medication.
    b. The seizure will run its course.
    c. Please note – The student is not in pain.
    d. **IT IS IMPORTANT TO TIME THE SEIZURE.**
2. EASE THE STUDENT TO THE FLOOR
    a. If the seizure begins while the student is seated, gently put him or her on the floor on the side while pushing away any close desks or furniture.
3. DO NOT INTERFERE WITH BODY MOVEMENT
    a. Try to prevent the student from striking his or her head by putting something soft such as a pillow, blanket or soft jacket under the head.
    b. **DO NOT PHYSICALLY RESTRAIN THE STUDENT.**
4. DO NOT INSERT ANYTHING BETWEEN THE STUDENT'S TEETH
    a. There may be violent teeth clenching during the seizure. Teeth may be broken or gums injured in attempting to put objects in mouth.
5. DO NOT BE FRIGHTENEDD IF BREATHING APPEARS TO STOP MOMENTARILY
    a. Breath should resume spontaneously.
    b. **RESUCITATION MAY BE HARMFUL.**
6. WHEN THE STUDENT BECOMES QUIET, MAKE SURE STUDENT STAYS ON HIS/HER SIDE
    a. Saliva and/or vomitus can drain out and this position protects the child from inhaling the drainage.
7. AFTER THE MOVEMENTS HAVE STOPPED AND THE CHILD IS RELAXED, LET HIM OR HER REST
    a. Sleep or rest is often needed after a seizure.

PARTIAL or ABSENCE seizures are less dramatic and usually only require observation unless the movement puts the student in danger of harming him or herself (then: follow the steps above).

1. Partial Seizures involve simple, non-purposeful movement of an arm, leg, jaw, lip smacking, or rhythmic movement of the eyes.
2. Absence Seizures include altered awareness or attention and blank stare.
    a. This type of seizure is often mistaken for learning disabilities or behavior problems.
3. If you have a student who displays "moments of absence" or any of the above mentioned behavior for partial seizures, please notify the school's Health Care Office.

LYON COUNTY SCHOOL DISTRICT
HEALTH SERVICES
SEIZURE REPORT

Complete form for all Grand Mal seizures. Parents MUST be notified.

Student:_____ Date:_____

Location:_____

Start Time:_____ End Time:_____ Duration: _____

What was the student doing when the seizure started? _____

_____

_____

Did anything seem to have triggered the seizure? _____

_____

_____

In what part of the body was the seizure first noticed? _____

_____

_____

Circle responses as appropriate:

- Was the student unconscious during the seizure? Yes No Not Observed
- Which part of the body was involved? Right Left Both Not Observed
- Type of movement? Clonic (limp muscles) Tonic (rigid muscles) Not Observed
- Did student strike his or her head? Yes No Not Observed
- Was there excessive salivation? Yes No Not Observed
- Did the lips or face change color? Yes No Not Observed
- Was there urinary incontinence? Yes No Not Observed
- Was there fecal (bowel movement) incontinence? Yes No Not Observed
- Immediately after the seizure, was there lethargy (Extreme tiredness)? Yes No Not Observed
- Immediately after the seizure, was there confusion? Yes No Not Observed
- Headache? Yes No Not Observed
- Speech Impairment? Yes No Not Observed

Description: _____

_____

_____

Staff Signature and Title: _____

Name _____ Date _____

Teacher/Period _____ In _____

Referred by _____ Out _____

Symptom		Observation		Assessment		Plan	
Does Not Feel Well		Temperature		Laceration/Abrasion		Reset RTC	
Headache		Bump		Sprain		Reassured RTC	
Stomachache		Red Throat		No s/s Injury		First Aid RTC	
Sore Throat		Enlarged Glands		No s/s Illness		Recheck At:	
Vomiting		Vomited/Nausea		No s/s/ Infection		Contact Parent	
Earache		Stuffy Nose		Head Injury		Sent Home	
Toothache		Cough		URI		Info to Parent	
Difficulty Breathing		Lungs CTA/Wheeze		Ineffective Resp.		PRN Med	
Overheated		PERL		Needing TLC		Ice Pack	
Fall		Blood On/From		MD Eval Needed		Snack/Hydrate	
Head Itches		Red/Water/Matted		Afebrile		Health Teaching	
Nosebleed		Color				Nurse's Note to IC	
Eye Hurts/Itches							

Notes: _____

Signature: _____ Over: _____

Name _____ Date _____

Teacher/Period _____ In _____

Referred by _____ Out _____

Symptom		Observation		Assessment		Plan	
Does Not Feel Well		Temperature		Laceration/Abrasion		Reset RTC	
Headache		Bump		Sprain		Reassured RTC	
Stomachache		Red Throat		No s/s Injury		First Aid RTC	
Sore Throat		Enlarged Glands		No s/s Illness		Recheck At:	
Vomiting		Vomited/Nausea		No s/s/ Infection		Contact Parent	
Earache		Stuffy Nose		Head Injury		Sent Home	
Toothache		Cough		URI		Info to Parent	
Difficulty Breathing		Lungs CTA/Wheeze		Ineffective Resp.		PRN Med	
Overheated		PERL		Needing TLC		Ice Pack	
Fall		Blood On/From		MD Eval Needed		Snack/Hydrate	
Head Itches		Red/Water/Matted		Afebrile		Health Teaching	
Nosebleed		Color				Nurse's Note to IC	
Eye Hurts/Itches							

Notes: _____

Signature: _____ Over: _____

Warren Reed
INSURANCE

REPORT OF ACCIDENT TO STUDENT

SCHOOL DISTRICT		
SCHOOL NAME	STREET	CITY
STUDENT'S **NAME**	GRADE	**AGE**
STUDENT'S ADDRESS		TELEPHONE
TEACHER'S NAME	STREET	**CITY**

PLACE WHERE ACCIDENT OCCURRED | **DAY** | TIME

CHECK POSSIBLE NATURE OF INJURY

c:J ABRASION (SCRAPED WOUND)
c:J CONTUSION (BRUISED WOUND)
c:J LACERATION (TORN WOUND)
0 INCISED WOUND (CLEAN OUT)
c:J STRAIN OR **SPRAIN**
c:J DISLOCATION
c:J FRACTURE
c:J INTERNAL INJURY

CHECK PART OF BODY INJURED

c:J HEAD: SCALP FACE_ EYE_
c:J NECK
c:J ARMS: ARM FOREARM___ HANO_
c:J CHEST
c:J ABDOMEN
c:J BACK (INCLUDING SPINE)
c:J PELVIS
c:J LEGS: THIGH___ LEG___ FOOT_

CAUSE OF INJURY

NAMES OF PERSONS PRESENT· WITNESS	ADDRESS	CITY
1.		
2.		
3.		

IMMEDIATE ACTION TAKEN

c:J FIRST-AID TREATMENT — GIVEN BY
c:J SENT TO SCHOOL NURSE — **BY** _____
c:J SENT HOME — **BY** _____
0 SENT TO PHYSICIAN — **BY**
0 SENT TO HOSPITAL — BY _____

NAME OF **PHYSICIAN** | **NAME** OF HOSPITAL

Was a parent or other individual notified? YES__ NO__ WHEN?__ HOW?__
Name of individual notified _____

y8 whom? _____

Does injured hava accident insurance through a student group plan? YES___NO___
Probable duration of absence from school _____

SIGNATURE OF **PRINCIPAL** | DATE OF REPORT

LYON COUNTY SCHOOL DISTRICT
HEALTH SERVICES
VISION REFERRAL

Please take this with you to your eye doctor when you go for further examination.

Student's Name:_____ Date:_____

Age:_____ Grade: _____

Your child had a simple vision screen at school performed by the Health Services Office. It is recommended that an eye doctor examine him/her.

Screening Report:

NEAR:		DISTANCE:	
Right Eye:	_____	Right Eye:	_____
Left Eye:	_____	Left Eye:	_____
Both Eyes:	_____	Both Eyes:	_____

Doctors Report and Recommendations: _____

_____

_____

_____

_____

Doctor's Signature:_____ Date: _____

Please Return Report to:

_____

_____

_____

Attn: Health Services Office