

TEXAS CITY

INDEPENDENT SCHOOL DISTRICT



TOGETHER WE **SUCCEED**

2025-26
HEALTH
INFORMATION
HANDBOOK

Parent / Student Handbook of School Health Information Acknowledgment Form

My child and I have received a copy of the **Parent / Student Handbook of School Health Information** for 2025-2026. I understand that the handbook contains information that my child and I may need during the school year.

Printed name of Student: _____

Print name of Parent: _____

Signature of Parent: _____

Emergency telephone number: _____

Date: _____

School: _____

Grade Level: _____

Please sign this page and complete the requested information. Remove the page from the handbook and return it to your child's school within 10 school days of enrollment. Thank you.

**Parent/Student Handbook of
School Health Information
Acknowledgement Form**

My child and I have been offered the option to receive a paper copy or to electronically access at www.tcisd.org the Texas City ISD Parent/Student Handbook of School Health Information for 2025-2026. I have chosen to:

- Accept responsibility to pick up a paper copy of the TCISD Parent/Student Handbook of School Health Information from the school office.
- Accept responsibility for accessing the Student Handbook by visiting the Web address listed above.

I understand that the handbook contains information that my child and I may need during the school year

Printed name of student: _____

Printed name of parent: _____

Signature of parent: _____

Emergency Phone Number: _____

School: _____

Grade Level: _____

Date: _____

Please sign and date this page and return it to your campus office staff with in the first week of the 2025-2026 school year.

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SECTION I

Directory of School Clinics

Calvin Vincent Pre-Kindergarten/Headstart

Mario Garcia 409-916-0512 ext. 2354 msgarcia@tcisd.org

Guajardo Elementary

Shelley Cox 409-916-0300 ext. 1305 scox@tcisd.org

Hayley Elementary

Laura Prino 409-935-3020 ext. 5205 lprino@tcisd.org

Heights Elementary

Melissa Peck 409-916-0500 ext. 1507 mpeck@tcisd.org

Kohfeldt Elementary

Melissa Guevara 409-916-0400 ext. 1448 mguevara@tcisd.org

Roosevelt-Wilson Elementary

Spring Bucior 409-916-0200 ext. 1205 sbucior@tcisd.org

Simms Elementary

Stacy Smith 409-908-5100 ext. 5117 sns smith@tcisd.org

Levi-Fry Intermediate

Stephanie Martin 409-916-0600 ext. 1663 stmartin@tcisd.org

Blocker Middle School

Melissa McCoy 409-916-0700 ext. 1713 mmcoy@tcisd.org

Giles Middle School

Ashley Elliott 409-938-4286 ext. 5393 aelliott@tcisd.org

La Marque High School

Monique Butler 409-938-4261 ext. 5509 mbutler@tcisd.org

Texas City High School

Michelle Hingle 409-916-0800 ext. 1840 mhingle@tcisd.org

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SECTION II

Immunizations

A student must be fully immunized against certain diseases or must present a certificate or statement that, for medical reasons or reasons of conscience, including a religious belief, the student will not be immunized.

For exemptions based on reasons of conscience, only official forms issued by the Department of State Health Services, Immunization Division, can be honored by the District.

The immunizations required are: diphtheria, rubeola (measles), rubella, mumps, tetanus, haemophilus influenzae type B, meningococcal, poliomyelitis, hepatitis A, hepatitis B, and varicella (chicken pox).

The school nurse can provide information on age-appropriate doses or on an acceptable physician-validated history of illness required by the Department of State Health Services. Proof of immunization may be personal records from a licensed physician or public health clinic with a signature or rubber-stamp validation.

If a student should not be immunized for medical reasons, the student or parent must present a certificate signed by a U.S. licensed physician stating that, in the doctor's opinion, the immunization required poses a significant risk to the health and well-being of the student or any member of the student's family or household. This certificate must be renewed yearly unless the physician specifies a life-long condition.

[For further information, see policy FFAB and the Department of State Health Services Web site:

<http://www.dshs.texas.gov/immunize/school/default.shtm>]

2025 - 2026 Texas Minimum State Vaccine Requirements for Students Grades K - 12

This chart summarizes the vaccine requirements incorporated in the Texas Administrative Code (TAC), Title 25 Health Services, §§97.61-97.72. This document is not intended as a substitute for the TAC, which has other provisions and details. The Department of State Health Services (DSHS) is granted authority to set immunization requirements by the Texas Education Code, Chapter 38.

IMMUNIZATION REQUIREMENTS

A student shall show acceptable evidence of vaccination prior to entry, attendance, or transfer to a public or private elementary or secondary school in Texas.

Vaccine Required (Attention to notes and footnotes)	Minimum Number of Doses Required by Grade Level											Notes		
	Grades K - sixth						Grade seventh	Grades eighth-12th						
	K	1	2	3	4	5	6	7	8	9	10		11	12
Diphtheria/Tetanus/ Pertussis(DTaP/DTP/DT/ Td/Tdap)	Five doses or four doses						Three dose primary series and one booster dose of tdap / td within the last five years	Three dose primary series and one booster dose of tdap / td within the last 10 years						For K – sixth grade: five doses of diphtheria-tetanus-pertussis vaccine; one dose must have been received on or after the fourth birthday. However, four doses meet the requirement if the fourth dose was received on or after the fourth birthday. ¹ For students aged 7 years and older, three doses meet the requirement if one dose was received on or after the fourth birthday. ¹ For seventh grade: one dose of Tdap is required if at least five years have passed since the last dose of tetanus-containing vaccine.* For eighth – 12th grade: one dose of Tdap is required when 10 years have passed since the last dose of tetanus-containing vaccine. **Td is acceptable in place of Tdap if a medical contraindication to pertussis exists.
Polio	Four doses or three doses											For K-12th grade: four doses of polio; one dose must be received on or after the fourth birthday. ¹ However, three doses meet the requirement if the third dose was received on or after the fourth birthday. ¹ Polio vaccine is not required for persons eighteen years of age or older.		
Measles, Mumps, and Rubella ² (MMR)	Two doses											For K – 12th grade: two doses are required, with the first dose received on or after the first birthday. ¹ Students vaccinated prior to 2009 with two doses of measles and one dose each of rubella and mumps satisfy this requirement		
Hepatitis B ²	Three doses											For students aged 11 – 15 years, two doses meet the requirement if adult hepatitis B vaccine (Recombivax [®]) was received. Dosage (10 mcg /1.0 mL) and type of vaccine (Recombivax [®]) must be clearly documented. If Recombivax [®] was not the vaccine received, a three dose series is required.		
Varicella ^{2,3}	Two doses											For K – 12th grade: two doses are required, with the first dose received on or after the first birthday. ¹		
Meningococcal (MCV4)							One dose					For seventh – 12th grade, one dose of quadrivalent meningococcal conjugate vaccine is required on or after the student's 11th ¹ birthday.		
Hepatitis A ²	Two doses											For K – 12th grade: two doses are required, with the first dose received on or after the first birthday. ¹		

NOTE: Shaded area indicates that the vaccine is not required for the respective grade.

↓ Notes on the back page, please turn over. ↓

¹ Receipt of the dose up to (and including) four days before the birthday will satisfy the school entry immunization requirement.

² Serologic evidence of infection or serologic confirmation of immunity to measles, mumps, rubella, hepatitis B, hepatitis A, or varicella is acceptable in place of vaccine.

³ Previous illness may be documented with a written statement from a physician, school nurse, or the child's parent or guardian containing wording such as: "This is to verify that (name of student) had varicella disease (chickenpox) on or about (date) and does not need varicella vaccine." This written statement will be acceptable in place of any and all varicella vaccine doses required.

Information on exclusions from immunization requirements, provisional enrollment, and acceptable documentation of immunizations may be found in §97.62, §97.66, and §97.68 of the Texas Administrative Code, respectively and online at dshs.texas.gov/immunizations/school

Exemptions

Texas law allows (a) physicians to write medical exemption statements which clearly state a medical reason exists that the person cannot receive specific vaccines, and (b) parents/guardians to choose an exemption from immunization requirements for reasons of conscience, including a religious belief. The law does not allow parents/guardians to elect an exemption simply because of inconvenience (for example, a record is lost or incomplete and it is too much trouble to go to a physician or clinic to correct the problem). Schools should maintain an up-to-date list of students with exemptions, so they may be excluded in times of emergency or epidemic declared by the commissioner of public health.

Instructions for requesting the official exemption affidavit that must be signed by parents/guardians choosing the exemption for reasons of conscience, including a religious belief, can be found at dshs.texas.gov/immunization/school/exemptions. The original Exemption Affidavit must be completed and submitted to the school.

For children claiming medical exemptions, a written statement by the physician must be submitted to the school. Unless it is written in the statement that a lifelong condition exists, the exemption statement is valid for only one year from the date signed by the physician.

Provisional Enrollment

All immunizations must be completed by the first date of attendance. The law requires that students be fully vaccinated against the specified diseases. A student may be enrolled provisionally if the student has an immunization record that indicates the student has received at least one dose of each specified age-appropriate vaccine required by this rule. Student must not be overdue for the next dose in a series to be considered provisional. To remain enrolled, the student must complete the required subsequent doses in each vaccine series on schedule and as rapidly as is medically feasible and provide acceptable evidence of vaccination to the school.

A school nurse or school administrator shall review the immunization status of a provisionally enrolled student every 30 days to ensure continued compliance in completing the required doses of vaccination. If, at the end of the 30-day period, a student has not received a subsequent dose of vaccine, the student is not in compliance and the school shall exclude the student from school attendance until the required dose is administered.

Additional guidelines for provisional enrollment of students transferring from one Texas public or private school to another, students who are dependents of active duty military, students in foster care, and students who are homeless can be found in the TAC, Title 25 Health Services, Sections 97.66 and 97.69.

Documentation

Since many types of personal immunization records are in use, any document will be acceptable provided a physician or public health personnel has validated it. Validation includes a signature, initials, or stamp. An immunization record generated from an electronic health record must include clinic contact information and the provider's signature/stamp, along with the vaccine name and vaccination date (month, day, and year). An official record generated from a health authority is acceptable. An official record received from school officials, including a record from another state is acceptable.



TEXAS
Health and Human
Services

Texas Department of State
Health Services

Texas Department of State Health Services • Immunizations • MC-1946 • P. O. Box 149347 • Austin, TX 78714-9347 • 800-252-9152

Requisitos mínimos de vacunas en Texas de 2025 -2026 para estudiantes de kínder a 12.o grado

Esta gráfica resume los requisitos de vacunación incorporados al Código Administrativo de Texas (TAC), título 25, Servicios de salud, secciones 97.61 a 97.72. Este documento no tiene como propósito sustituir al TAC, el cual contempla otras disposiciones y detalles. El Código de Educación de Texas, capítulo 38, confiere al Departamento Estatal de Servicios de Salud (DSHS) la autoridad para establecer los requisitos de inmunización.

REQUISITOS DE INMUNIZACIÓN

Los estudiantes deberán mostrar comprobantes de vacunación aceptables antes de inscribirse, asistir o ser transferidos a una guardería o una escuela primaria o secundaria pública o privada de Texas.

Vacuna requerida (Attention a notas y notas de pie de página)	Número mínimo de dosis requeridas por nivel de grado											Notes
	Kínder a sexto grado						Septimo grado	Octavo a 12.o grado				
	K	1	2	3	4	5	6	7	8	9	10	
Difteria, tétanos, tos ferina (DTaP, DTP, DT, Td, Tdap)	Cinco dosis o cuatro dosis						Una serie primaria de tres dosis y un refuerzo de la vacuna tdap/ td dentro de los últimos cinco años	Una serie primaria de tres dosis y un Refuerzo de la vacuna tdap / td Dentro de los últimos 10 años				Para los grados kínder a sexto: cinco dosis de la vacuna contra la difteria, el tétanos y la tosferina; debe haberse recibido una dosis en o después del cuarto cumpleaños. Sin embargo, con cuatro dosis se cubre el requisito si la cuarta dosis se recibió en o después del cuarto cumpleaños. ¹ Para los estudiantes de 7 años de edad o más, con tres dosis cumplen con el requisito si recibieron una de las dosis en o después del cuarto cumpleaños. ¹ Para el septimo grado: Se requiere una dosis de la vacuna Tdap si han pasado al menos 5 años desde la última dosis de una vacuna que contenga tétanos.* Para los grados octavo a 12.o: Se requiere una dosis de la vacuna Tdap cuando hayan pasado 10 años desde la última dosis de una vacuna que contenga tétanos.* *La vacuna Td es aceptable en lugar de la vacuna Tdap si existe una contraindicación médica para la vacuna contra la tosferina.
Polio	Cuatro dosis o tres dosis											Para los grados kínder a 12.o: cuatro dosis de la vacuna contra la polio; debe recibirse una dosis en o después del cuarto cumpleaños. ¹ Con tres dosis se cumple con el requisito si la tercera dosis se recibió en o después del 4.o cumpleaños. ¹ Gente mayor de 18 años no requieren una dosis de polio
Sarampión, paperas y rubeola ² (MMR)	Dos dosis											Para los grados kínder a 12.o: Se requieren dos dosis de la vacuna, la primera de las cuales debe recibirse en o después del primer cumpleaños. ¹ Los estudiantes que fueron vacunados antes de 2009 con dos dosis contra el sarampión y una dosis contra la rubeola y una dosis contra las paperas cumplen con este requisito.
Hepatitis B ²	Tres dosis											Para los estudiantes de 11 a 15 años de edad, con dos dosis cumplen con el requisito si recibieron la vacuna contra la hepatitis B para adultos (Recombivax®). Tanto la dosis (10 mcg / 1.0 mL) como el tipo de vacuna (Recombivax®) deben documentarse claramente. Si la vacuna recibida no fue Recombivax®, se requiere una serie de tres.
Varicella ^{2,3}	Dos dosis											Para los grados kínder a 12.o: Se requieren 2 dosis, de las cuales la 1.a dosis debe recibirse en o después del 1.er cumpleaños. ¹
Vacuna antimeningocócica (MCV4)							Una dosis				Para los grados 7.o a 12.o, se requiere 1 dosis de la vacuna antimeningocócica tetravalente conjugada en o después del 11.o cumpleaños del estudiante.	
Hepatitis A ²	Dos dosis											Para los g rados kínder a 1 2.o: Son necesarias 2 dosis, la 1a de las cual es debe re cibirse en o después del 1er cumpleaños. ¹

NOTA: Las casillas sombreadas indican que no se requiere la vacuna para el grupo de edad correspondiente.

↓ Notas al reverso, por favor dé la vuelta. ↓

¹Recibir la dosis hasta (e inclusive) cuatro días antes del cumpleaños satisfará el requisito de inmunización para inscribirse en la escuela.

²Son aceptables en lugar de la vacuna una prueba serológica de infección o la confirmación serológica de inmunidad al sarampión, las paperas, la rubeola, la hepatitis B, la hepatitis A o la varicela

³Si se ha tenido la enfermedad previamente, puede documentarse con una declaración escrita de un médico, un enfermero escolar o uno de los padres o tutor del niño, la cual diga algo como: “Esto es para comprobar que (nombre del estudiante) tuvo la enfermedad de la varicela (varicella o chickenpox) el (fecha) o alrededor de esa fecha y no necesita la vacuna contra la varicela”. Dicha declaración escrita será aceptable en lugar de alguna o todas las dosis requeridas de la vacuna contra la varicela.

Podrá encontrar información sobre las exclusiones de requisitos de vacunas, la inscripción provisional y la documentación aceptada de las vacunas en las secciones 97.62, 97.66 y 97.68 del Código Administrativo de Texas, respectivamente, y en línea en dshs.texas.gov/immunizations/school (en inglés).

Exenciones

La ley de Texas autoriza a que (a) los médicos redacten declaraciones de exención médica, las cuales deben indicar claramente que existe una razón médica que le impide a la persona recibir determinadas vacunas específicas, y (b) los padres o tutores opten por una exención de los requisitos de inmunización por razones de conciencia, incluidas las creencias religiosas. La ley no permite que los padres o tutores opten por una exención simplemente para evitarse inconvenientes (por ejemplo, cuando un registro se haya perdido o esté incompleto y sea mucha molestia ir con un médico o a una clínica para corregir el problema). Las escuelas deben mantener una lista actualizada de los estudiantes con exenciones, de forma que se les pueda excluir en casos de emergencias o epidemias declaradas por el comisionado de salud pública.

Encontrará las instrucciones para solicitar la declaración jurada de exención oficial, la cual debe ser firmada por los padres o tutores que elijan la exención por razones de conciencia, incluidas las creencias religiosas, en dshs.texas.gov/immunizations/school/exemptions (en inglés). El original de la declaración jurada de exención debe llenarse y entregarse en la escuela.

En el caso de los niños para quienes se reclamen exenciones médicas, es necesario presentar a la escuela una declaración escrita del médico. A menos que en la declaración conste por escrito que existe una afección de por vida, la declaración de exención es válida solo por un año a partir de la fecha en que el médico la firmó.

Provisional Enrollment

Todas las inmunizaciones deben haberse completado antes del primer día de asistencia. La ley exige que los estudiantes estén completamente vacunados contra las enfermedades específicas. Un estudiante puede inscribirse de manera provisional si cuenta con un registro de inmunización que indique que el estudiante ha recibido al menos una dosis de cada vacuna específica apropiada para su edad según lo exige esta regla. Para que el estudiante se considere como inscrito de manera provisional, no debe estar atrasado en su calendario para recibir la siguiente dosis que le corresponda en la serie de dosis de la vacuna. Para seguir inscrito, el estudiante debe completar las dosis posteriores requeridas de cada serie de vacunas a tiempo según el calendario y tan rápidamente como sea médicamente posible, y debe proporcionar a la escuela un comprobante aceptable de que ha sido vacunado.

Un enfermero escolar o administrador escolar revisará cada 30 días el estado de inmunización de los estudiantes inscritos de manera provisional para garantizar el cumplimiento ininterrumpido de la aplicación de las dosis de vacunas requeridas. Si, al final del periodo de 30 días, un estudiante no ha recibido una dosis posterior de la vacuna, el estudiante no está cumpliendo con las normas, y la escuela excluirá al estudiante de su asistencia a la escuela hasta que se le administre la dosis requerida.

Las normas adicionales para la inscripción provisional de estudiantes transferidos de una escuela pública o privada de Texas a otra, estudiantes que dependen de militares en servicio activo, estudiantes que viven en hogar de acogida y estudiantes en situación sin hogar, se encuentran en el TAC, título 25, Servicios de salud, secciones 97.66 y 97.69.

Documentation

Dado que se usan muchos tipos de registros de inmunización personales, cualquier documento es aceptable si un médico o el personal de salud pública lo ha validado. La validación debe incluir una firma del responsable, sus iniciales o el sello. Un registro de vacunas generado a partir de un registro de salud electrónico debe incluir la información de contacto de la clínica y la firma o sello del proveedor, junto con el nombre de la vacuna y la fecha de vacunación (mes, día y año). Se acepta un registro oficial elaborado por una autoridad sanitaria. Se acepta un registro oficial recibido de parte de los funcionarios de la escuela, incluido un registro procedente de otro estado.



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Exemptions

The law allows (a) physicians to write a statement stating that the vaccine(s) required would be medically harmful or injurious to the health and well-being of the child, and (b) parents/guardians to choose an exemption from immunizations requirements for reasons of conscience, including a religious belief. The law does not allow parents/guardians to elect an exemption simply because of inconvenience (a record is lost or incomplete and it is too much trouble to go to a physician or clinic to correct the problem).

For children needing medical exemptions, a written statement by the physician should be submitted to the school.

Instructions for the affidavit to be signed by parents/guardians choosing the exemption for reasons of conscience, including a religious belief can be found at www.ImmunizeTexas.com.

Schools should maintain an up-to-date list of students with exemptions, so they can be excluded from attending school if an outbreak occurs.

Provisional Enrollment

All immunizations should be completed by the first date of attendance. The law requires that students be fully vaccinated against the specified diseases. A student may be enrolled provisionally if the student has an immunization record that indicates the student has received at least one dose of each specified age-appropriate vaccine required by this rule. To remain enrolled, the student must complete the required subsequent doses in each vaccine series on schedule and as rapidly as is medically feasible and provide acceptable evidence of vaccination to the school. A school nurse or school administrator shall review the immunization status of a provisionally enrolled student every 30 days to ensure continued compliance in completing the required doses of vaccination. If, at the end of the 30-day period, a student has not received a subsequent dose of vaccine, the student is not in compliance and the school shall exclude the student from school attendance until the required dose is administered.

Additional guidelines for provisional enrollment of students transferring from one Texas public or private school to another, students who are dependents of active duty military, and students who are homeless can be found in the TAC, Title 25 Health Services, Sections [97.66](#) and [97.69](#).

Documentation

Since many types of personal immunization records are in use, any document will be acceptable provided a physician or public health personnel have validated it. The month, day, and year that the vaccination was received must be recorded on all school immunization records created or updated after September 1, 1991.

For additional information or clarification, please contact the Texas Department of State Health Services, Immunization Branch at (800) 252-9152, visit the website at www.ImmunizeTexas.com, or contact your child's school nurse.

TB Questionnaire

Name of Child _____ Date of Birth _____

Organization administering questionnaire _____ Date _____

Tuberculosis (TB) is a disease caused by TB germs and is usually transmitted by an adult person with active TB lung disease. It is spread to another person by coughing or sneezing TB germs into the air. These germs may be breathed in by the child.

Adults who have active TB disease usually have many of the following symptoms: cough for more than two weeks duration, loss of appetite, weight loss of ten or more pounds over a short period of time, fever, chills and night sweats. A person can have TB germs in his or her body but not have active TB disease (this is called latent TB infection or LTBI).

Tuberculosis is preventable and treatable. TB skin testing (often called the PPD or Mantoux test) is used to see if your child has been infected with TB germs. No vaccine is recommended for use in the United States to prevent tuberculosis. The skin test is not a vaccination against TB.

We need your help to find out if your child has been exposed to tuberculosis.

Place a mark in the appropriate box:	Yes	No	Not Sure
TB can cause fever of long duration, unexplained weight loss, a bad cough (lasting over two weeks), or coughing up blood. As far as you know: Has your child been around anyone with any of these symptoms or problems? or Has your child had any of these symptoms or problems? or Has your child been around anyone sick with TB?			
Was your child born in Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe or Asia?			
Has your child traveled in the past year to Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe or Asia for longer than 3 weeks? If so, specify which country/countries			
To your knowledge, has your child spent time (longer than 3 weeks) with anyone who is/has been an avenous (IV) drug user, HIV-infected, in jail or prison or recently came to the United States from her country?			

Has your child been tested for TB? Yes _____ (if yes, specify date _____) No _____

Has your child ever had a positive TB skin test? Yes _____ (if yes, specify date _____) No _____

or school/healthcare provider use only

PPD administered Yes _____ No _____ If yes;

Date administered _____ Date read _____ Result of PPD test _____ mm response _____

Type of service provider (i.e. school, Health Steps, other clinics) _____

PPD provider _____

Signature

Printed Name

Provider phone number _____

City _____ County _____

If positive, referral to healthcare provider Yes _____ No _____

If yes, name of provider _____

SECTION III

Student Illnesses

Texas City school nurses are proud to be a part of your child's education. Success in school is directly related to the good health and emotional well-being of each student. *Responsibility for the care of children lies primarily with parents.* The nurses in TCISD are here to assist and support parent's efforts to maintain good health in their children. **School nurses do not diagnose.** School nurses assess and make recommendations based on that assessment. For the protection of all students, the following health rules have been set up and will be followed at all times. A child cannot remain in school with:

- 1) Fever of 100 degrees or over a student must be FREE FROM FEVER WITHOUT MEDICATION for 24 hours before returning to school,
- 2) Rash or weeping sores,
- 3) Vomiting – student should be free from vomiting for 24 hours before returning to school
- 4) Diarrhea – Students with diarrhea illnesses must stay home until they are diarrhea free without diarrhea suppressing medications for at least 24 hours. Soiled clothing will be sent home with the student,
- 5) Red, discharging eyes, or at the discretion of the school nurse,
- 6) Students complaining of headache/stomachache/menstrual cramps with no fever or other symptoms are not required to be excluded from school. The parent/ guardian may be contacted and they can decide whether to pick up the student. If they do, it will be a Parent Requested Early Dismissal.
- 7) Please do not send ill or injured students to school to be diagnosed by school personnel.
* A student may be sent home at the nurse's discretion in accordance with the guidelines from the CDC and the Texas Department of State Health Services.

A student having any of the above symptoms BEFORE SCHOOL SHOULD STAY AT HOME for observation and care. There are limited facilities for putting students to bed. This option will be used only until arrangements can be made for the student to go home. A student will not be sent home to be left alone without special arrangements and written permission from the parent.

Students who have been absent from school because of a communicable disease or illness diagnosed as strep throat, scarlet fever, or skin disease (Staph/MRSA skin infection, ringworm, impetigo) or pink eye are required to bring a doctor's statement authorizing return to school. Due to an illness or injury, any student who misses three consecutive days of school must return with a note from the Doctor authorizing the return to school. The school nurse is not in a position to diagnose or treat illnesses. For question about diagnosis or treatment, a medical doctor should be consulted.

The wheelchair in the nurse's clinic is ONLY for emergencies. If a student needs a wheelchair or crutches during school hours, he/she must provide their own, as well as medical documentation from a physician that the use of the equipment is medically necessary on campus during the school day.

Emergency First Aid Care

Any treatment given at school is limited to first aid. When a pupil becomes ill or is injured at school, parents are notified. If they cannot be reached and the situation requires medical attention beyond our resources, it may be necessary to send the student to the hospital emergency service for needed care until the parents can be reached. Parents are responsible for emergency care costs.

Parents should supply the school nurse with information concerning current special health problems that are under the care of a physician. The nurse cannot give any medications while waiting for you to pick up your child.

Contagious Diseases

The following table lists the most common contagious diseases and infestations, the incubation period of each, and the requirements for re-admission to school. For COVID-19 information please refer to the Reopening TCISD Safely Plan at <http://www.tcisd.org/reopening> .

Common Contagious Diseases	Incubation Period	Requirements for Re-admission to School
Chicken Pox	2-3 weeks	Exclude for 7 days after eruption and until lesions are dry. Temperature must be normal.
Impetigo	N/A	Exclude from school until healed or until noninfectious according to a physician's written statement.
Infectious Hepatitis	15-50 days Notify school as soon as physician confirms diagnosis	Exclude until no fever and no jaundice, or until noninfectious according to a physician's written statement.
Measles	10 days to fever or 14 days to rash	Exclude when symptoms first develop and for five days after the appearance of rash.
Mumps	12-26 days	Exclude until all swelling subsides.
Pink Eye	24-72 hours	Exclude until 24 hours after prescribed treatment has begun - or a physician's written statement
Ringworm of the Body	4-10 days	May attend school provided child is receiving treatment at home and affected areas must be covered at all times.
Ringworm of the Scalp	10-21 days	Exclude until after treatment has begun. Child must be under treatment of a physician. May return with physician's written statement.
Streptococcal Infection	1-3 days	Exclude and may return 24 hours after effective antibiotic treatment has begun and no fever.
Head Lice	N/A	Exclude until visual inspection shows that no live lice are found.
Scabies	N/A	Exclude until physician's written statement certifies that the child has been properly treated and cleared to return to school.
Fever	N/A	Children must be excluded from school if they have a temperature >100.0 degrees Fahrenheit. Child must be free of fever without medication for 24-48 hours before they can return to school.
Influenza	N/A	Exclude and may return after there is no fever.
COVID		Student must be fever free for 24 hrs without medication before returning to school.

Head Lice/Treatment

TCISD Protocol for Lice (Pediculosis):

Texas City ISD School Nurses do not routinely screen for head lice. If there is a suspected case, the nurse will perform a head check on the student and follow up with a phone call to the parent or guardian if live lice are found.

We encourage you to check your child often, especially during cold weather. Remind your child not to share hats or grooming items with other students.

Texas City ISD follows Texas Department of State Health Services guidelines when dealing with lice. For more information, contact your student's school clinic.

Texas City ISD Policy:

- According to Texas City ISD policy, students must be sent home from school if live lice are found in their hair.
- Students will not be sent home if only nits are found.
- Texas City ISD policy also states students may return to school after one medicated shampoo or lotion treatment has been given.
- When returning to school a head check by the nurse is required by the school district.

Treatment:

- Treatment must be with a lice shampoo or cream rinse approved by the FDA.
- Combing and picking out of nits is necessary to remove the nits.
- A second treatment of lice shampoo or cream rinse 7-10 days after the first treatment is needed to kill remaining or newly hatched lice.

Management:

- If treated and cleared by the campus nurse, students may return to school the same day they were sent home.
- Mass screenings are not recommended or required.
- Families of students in the classroom will not be notified if only one case is found.
- If multiple cases are found, then the classroom parents will be notified.
- If multiple cases are found in one classroom, the school custodian will be notified so a thorough cleaning can be done.

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SECTION IV

Use of Repellant and Sunscreen at School

TEXAS CITY ISD PROCEDURES FOR INSECT REPELLANT USE DURING SCHOOL HOURS

- Concerned parents are strongly encouraged to use a repellant on their child before they leave for school, especially younger children who may have difficulty applying the repellant safely.
- No repellant sprays or lotions will be provided by or applied by school personnel during the school day.
-

SAFE USE OF INSECT REPELLANTS

- Always follow the label recommendations.
- Apply to exposed skin and clothing. Do not apply under clothing or over cuts, wounds, or irritated skin.
- Look for repellants that have DEET (N, N-diethyl-m-toluamide) for the best protection against mosquitoes.
- After returning indoors, wash treated skin with soap and water.
- Apply to face by putting repellant on hands and rubbing it carefully over the face.

USE OF SUNSCREEN PRODUCTS AT SCHOOL – SENATE BILL 265

- A student may possess and use a topical sunscreen product while on school property and at a school related event or activity to avoid overexposure to the sun.
- No aerosol products are permitted and the product must be approved by the FDA (Federal Drug Administration) for over the counter use.
- If it is necessary for the campus nurse or a campus employee to assist a student due to special needs, written permission from the parent will be required.

Medication at School

District employees will not give a student prescription medication, nonprescription medication, herbal substances, anabolic steroids, or dietary supplements, with the following exceptions:

Only authorized employees, in accordance with policies at FFAC, may administer:

- Prescription medication, in the original, properly labeled container, provided by the parent, along with a District form that has been signed by the student's physician and parent.
- Prescription medication from a properly labeled unit dosage container filled by a registered nurse or another qualified District employee from the original, properly labeled container (i.e. field trips).
- Nonprescription medication, in the original, properly labeled container, provided by the parent, along with a parent's written request and signature and with a physician's written approval.
- Herbal or dietary supplements provided by the parent only if required by the student's individualized education program (IEP) or Section 504 plan for a student with disabilities.
- A student with asthma or severe allergic reaction (anaphylaxis) may be permitted to possess and use prescribed asthma or anaphylaxis medication at school or school-related events only if he or she has written authorization from his or her parent and a physician or other licensed health-care provider. The student must also demonstrate to his or her physician or health-care provider and to the school nurse the ability to use the prescribed medication, including any device required to administer the medication. If the student has been prescribed asthma or anaphylaxis medication for use during the school day, the student and parents should discuss this with the school nurse or principal.

In accordance with a student's individual health plan for management of diabetes, a student with diabetes will be permitted to possess and use monitoring and treatment supplies and equipment while at school or at a school-related activity. See the school nurse or principal for information. [See policy FFAF (LEGAL).]

Texas City Independent School District-
Administration of Medications at School

Parents,

Your child may have an illness which requires medication for relief or cure that does not prevent his/her attending school. When possible, such medication should be scheduled to be taken at home. However, according to the Texas laws and Texas City ISD Board Policy, a medication may be dispensed to a student by school personnel. The following requirements must be met by the parent or legal guardian requesting this service:

1. All prescription drugs dispensed through a physician's office must be in their original pharmacy container or packaging and labeled by the pharmacist. The label must include:
 - a. The student's name
 - b. The physician's name and signature and parent signature
 - c. The name and strength of the drug
 - d. Amount of drug to be given
 - e. Frequency of administration
 - f. Date prescription was filled
2. All non-prescription drugs must be in their original container. This request must contain the following information before administration by school personnel:
 - a. Full name of student
 - b. Name of drug
 - c. Dosage must comply with manufacturer's recommendations
 - d. Scheduled hours when the drug is to be given
 - e. Reason drug is to be given
 - f. Date
 - g. Appropriate signatures (physician and parent)
3. Forms for non-prescription drugs administered at school will remain in effect for the remainder of the school year and will be dispensed to students as needed. Student's parents or guardians will be responsible for picking medications up at the end of the school year.
4. Medications prescribed or requested to be given three (3) times a day or less are not to be given at school unless a specific time during school hours is prescribed by a physician and listed on the prescription bottle. There will be no more than one medication per properly labeled container.
5. All medications will be stored in a locked cabinet and dispensed in the school clinic.
6. Students may not be in possession of prescription or non-prescription medications during school hours or a school-sponsored or school-related activity, on or off campus unless the medication is a life-saving medication.
7. Natural and/or homeopathic-like products not FDA approved will not be dispensed by school district personnel without a physician's order.
8. Narcotics will **NOT** be dispensed at school.
9. In accordance with the Texas Nurse Practice Act, Rule 217.11, the school nurse has the responsibility and authority to clarify any medication order with appropriate licensed practitioner and/or refuse to administer medication that, in the nurse's judgment, is not in the best interest of the student.
10. Students, of appropriate age, are held responsible for coming to the clinic to take their daily medications.
11. Medications for diabetes, asthma, severe allergic reactions, or other chronic illness has additional requirements. Let your school nurse know if you need additional information concerning these illnesses.

Permission to Administer Prescription or Non-Prescription Medication at School

Student Name		(Last)	(First)	(MI)	DOB
Any known allergies to drugs or foods? (list)					
Type of Medication (check one)			Name of Medication (Trade or generic)		
<input type="checkbox"/> Prescription <input type="checkbox"/> Non-Prescription					
Date to Begin Medication		Date to End Medication		Time to be Given	Amount to be Given
Reason medication is being given			Drug Classification (For Office Use Only)		
Form of Medication					
<input type="checkbox"/> Tablet <input type="checkbox"/> Capsule <input type="checkbox"/> Liquid (dispenser) <input type="checkbox"/> Inhalant <input type="checkbox"/> Other (list)					
Physician's Name Print		Physician's Signature		Office Phone	Date

Parent/Guardians-Please send only the amount the student needs to take at school in a properly labeled, original container. **The student will not be allowed to carry medications back and forth from home to school.** When the period of administering the medication expires, the medication must be picked up by the parent, legal guardian, or other person having legal control of the student. Medications will be discarded if not picked up within seven (7) calendar days after the period for administering has expired or the school year has ended, whichever occurs first.

Parent/Guardian Name		Parent/Guardian Signature		Date
Home Phone		Cell Phone		Work Phone

MEDICATION INVENTORY RECORD

To request medication administration at school please note:

- A new form is need for all changes in medication, dose, or time
- The medication should be brought to school by a parent/guardian or responsible adult
- Unless otherwise specified, medication order is valid for the current school year only
- All other rules and expectations are listed on front page

Date	Amount Received (count with parent or other Adult)	School Employee Signature	Parent/Guardian Signature

Medication returned to: _____ Date: _____

Date	Comments

SECTION V

Student Self Administration of Metered Dose Inhaler Guidelines

In accordance with policy FFAC (LEGAL), a student with asthma or severe allergic reaction (anaphylaxis) may be permitted to possess and use prescribed asthma or anaphylaxis medication at school or school-related events only if he or she has written authorization from his or her parent and a physician or other licensed health-care provider. The student must also demonstrate to his or her physician or health-care provider and to the school nurse the ability to use the prescribed medication, including any device required to administer the medication. If the student has been prescribed asthma or anaphylaxis medication for use during the school day, the student and parents should discuss this with the school nurse or principal.

Asthma Action Plan

Student's Name _____ Grade _____ Date of Birth: _____ School _____

Inhaler kept in _____ School clinic Self-carry



ACTION CONTROL PLAN

Level of Severity Intermittent Mild Intermittent Moderate Persistent Severe Persistent High Risk
Control Well controlled Not well controlled Very poorly Controlled
Triggers Animals Pollen Dust Mites Viral Respiratory Infections Mold Exercise Weather Smoke Other _____
Allergies _____

Pulse Ox

\geq 95% normal
 Other _____

If student has any of the following symptoms - chest tightness, difficulty breathing, wheezing, excessive coughing, shortness of breath you will do this: Stop activity and help student to a sitting position, stay calm, reassure student, assist student with use of inhaler if they self-carry, escort student to school clinic or call for nurse for immediate assistance. Never send student to clinic alone!!

GREEN ZONE

DOING WELL

- Breathing is normal
- No cough, wheeze, chest tightness, or shortness of breath during the day or night
- Can do usual activities

And, if a peak flow meter is used,
 Peak flow: more than _____

(80 percent or more of best peak flow)

Take these long-term control medicines each day.

Controller Medications	How much to take	When to take it	At School
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Rescue Medications	<input type="checkbox"/> 2 or <input type="checkbox"/> 4 puffs <input type="checkbox"/> 6 puffs	<input type="checkbox"/> 10 - 20 minutes before exercise	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	<input type="checkbox"/> PRN _____ hrs	_____	

YELLOW ZONE

ASTHMA IS GETTING WORSE

- Cough, wheeze, chest tightness, or shortness of breath, or
- Waking at night due to asthma, or
- Can do some, but not all, usual activities

-Or-
 If pulse Oximeter is used O2 Sat
 _____% to _____%

First Add: rescue medicine
 _____ 2 or 4 6 puffs, every _____ Minutes Repeat every _____ Minutes for up to 1 hour
 (short-acting beta2-agonist) Nebulizer solution _____ Repeat every _____ Minutes

Second If symptoms (and peak flow, if used) return to **GREEN ZONE** after 1 hour of above treatment:
 Continue monitoring to be sure student stays in the **GREEN ZONE**

-Or-
 If symptoms (and or pulse Ox, if used) do not return to **GREEN ZONE** after 1 hour of above treatment move to **RED ZONE**.

RED ZONE

MEDICAL ALERT! DANGER

- Very short of breath, or
- Rescue medicines have not helped,
- Cannot do usual activities, or
- Symptoms are same or get worse after treatment in **Yellow Zone** Pulse Oximeter < 93%

First Rescue medicine
 _____ 4 or 6 puffs every _____ Minutes or Nebulizer Solution every _____ Minutes
 (short-acting beta2-agonist)

Second Call 911 if unable to return action to yellow zone after 15 minutes or less, call 911, and parent/guardian.

EMERGENCY! Trouble walking and talking due to shortness of breath Lips or fingernails are blue Chest or neck is pulling in while breathing Student must bend forward to breathe

Self Administration By checking this box and signing below, health care provider and parent, give written authorization of permission for this student to self carry and self administer prescription asthma medication during school or at school related events. This includes authorization to coach and discuss this condition and elements of care with health care provider indicated on this form

Date _____ Provider Signature _____ Provider Printed Name _____ Provider Phone _____ Fax _____

Parent/Guardian: I give written authorization for the medications listed in the action plan to be administered in school by the nurse or other school members as appropriate.
 I consent to communication between the prescribing health care provider/clinic, the school nurse, the school medical advisor, and for asthma management and administration of this medication.

Date _____ Parent/guardian signature _____ Home phone/cell _____ Work _____ Alternate contact number _____

Nurse Signature: _____ Nurse Name: _____ Office Phone: _____ Fax: _____

How To Control Things That Make Your Asthma Worse

This guide suggests things you can do to avoid your asthma triggers. Put a check next to the triggers that you know make your asthma worse and ask your doctor to help you find out if you have other triggers as well. Then decide with your doctor what steps you will take.

Allergens

Animal Dander

Some people are allergic to the flakes of skin or dried saliva from animals with fur or feathers.

The best thing to do:

- Keep furred or feathered pets out of your home.

If you can't keep the pet outdoors, then:

- Keep the pet out of your bedroom and other sleeping areas at all times, and keep the door closed.
- Remove carpets and furniture covered with cloth from your home. If that is not possible, keep the pet away from fabric-covered furniture and carpets.

Dust Mites

Many people with asthma are allergic to dust mites. Dust mites are tiny bugs that are found in every home—in mattresses, pillows, carpets, upholstered furniture, bedcovers, clothes, stuffed toys, and fabric or other fabric-covered items.

Things that can help:

- Encase your mattress in a special dust-proof cover.
- Encase your pillow in a special dust-proof cover or wash the pillow each week in hot water. Water must be hotter than 130° F to kill the mites. Cold or warm water used with detergent and bleach can also be effective.
- Wash the sheets and blankets on your bed each week in hot water.
- Reduce indoor humidity to below 60 percent (ideally between 30—50 percent). Dehumidifiers or central air conditioners can do this.
- Try not to sleep or lie on cloth-covered cushions.
- Remove carpets from your bedroom and those laid on concrete, if you can.
- Keep stuffed toys out of the bed or wash the toys weekly in hot water or cooler water with detergent and bleach.

Cockroaches

Many people with asthma are allergic to the dried droppings and remains of cockroaches.

The best thing to do:

- Keep food and garbage in closed containers. Never leave food out.
- Use poison baits, powders, gels, or paste (for example, boric acid). You can also use traps.
- If a spray is used to kill roaches, stay out of the room until the odor goes away.

Indoor Mold

- Fix leaky faucets, pipes, or other sources of water that have mold around them.
- Clean moldy surfaces with a cleaner that has bleach in it.

Pollen and Outdoor Mold

What to do during your allergy season (when pollen or mold spore counts are high):

- Try to keep your windows closed.
- Stay indoors with windows closed from late morning to afternoon, if you can. Pollen and some mold spore counts are highest at that time.
- Ask your doctor whether you need to take or increase anti-inflammatory medicine before your allergy season starts.

Irritants

Tobacco Smoke

- If you smoke, ask your doctor for ways to help you quit. Ask family members to quit smoking, too.
- Do not allow smoking in your home or car.

Smoke, Strong Odors, and Sprays

- If possible, do not use a wood-burning stove, kerosene heater, or fireplace.
- Try to stay away from strong odors and sprays, such as perfume, talcum powder, hair spray, and paints.

Other things that bring on asthma symptoms in some people include:

Vacuum Cleaning

- Try to get someone else to vacuum for you once or twice a week, if you can. Stay out of rooms while they are being vacuumed and for a short while afterward.
- If you vacuum, use a dust mask (from a hardware store), a double-layered or microfilter vacuum cleaner bag, or a vacuum cleaner with a HEPA filter.

Other Things That Can Make Asthma Worse

- Sulfites in foods and beverages: Do not drink beer or wine or eat dried fruit, processed potatoes, or shrimp if they cause asthma symptoms.
- Cold air: Cover your nose and mouth with a scarf on cold or windy days.
- Other medicines: Tell your doctor about all the medicines you take. Include cold medicines, aspirin, vitamins and other supplements, and nonselective beta-blockers (including those in eye drops).



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SECTION VI

Diabetes Management and Treatment Plan

In accordance with a student's individual health plan for management of diabetes, a student with diabetes will be permitted to possess and use monitoring and treatment supplies and equipment while at school or at a school-related activity. See the school nurse or principal for information. [See policy FFAF.]

The parent or guardian of a student who will seek care for diabetes while at school or while participating in a school activity, and the physician responsible for the student's diabetes treatment, shall develop a Diabetes Management and Treatment Plan (DMTP).

The DMTP must:

1. Identify the health-care services the student may receive at school;
2. Evaluate the student's ability to manage and level of understanding of the student's diabetes; and
3. Be signed by the parent or legal guardian and the child's physician.

The parent or guardian must submit the DMTP to the school as soon as practicable following a diagnosis of diabetes for the student. [Health and Safety Code 168.002]

The school will work in concert with families of students with diabetes and will involve parents or legal guardians in the development of the DMTP.

Guidelines for Self-Management of Diabetes Medication at School

TCISD is fully committed to supporting our diabetic students who desire to carry their supplies and self-manage their diabetes while at school and school sponsored events. It is important that parents communicate with the school nurse, teachers, and coaches at the start of the school year regarding the student's diabetes care. Your school nurse will continue to be available to assist both the diabetic student and parents as needed. Please do not hesitate to enlist the support of TCISD's professional staff.

The safety of all TCISD students is a primary concern of our district staff. For the safety of the diabetic students as well as others, the following guidelines have been developed. **Please read and sign the bottom of this form and return it to the school nurse indicating that you have read the guidelines listed below.**

- Both parent and physician's signatures are required on the *Diabetic Management and Treatment Plan (DMTP)*, and must be on file in the school nurse's office before the student will be permitted to carry diabetic supplies at school. The form must be renewed at the beginning of every school year.
- The student must supply all diabetic equipment. The school does not stock reserve supplies. Parents are strongly encouraged to provide the school nurse with a secondary supply of emergency equipment (e.g. a glucometer, lancets and glucagons) in case the student becomes ill and his/her equipment is not available.
- Students may not share their equipment with other students. Stolen or missing supplies should be immediately reported to the school nurse or campus principal (if nurse is not available).
- Students are required to carry and properly use a personal sharps disposal container, and should care for puncture sites and blood in such a way that others are not inadvertently exposed to the student's blood.
- Diabetic supplies should be kept in the student's direct possession at all times so that other students can't easily access the supplies (The exceptions would be when the equipment is in the possession of a staff member.).
- Equipment should be stored in a safe manner (i.e. so that glass insulin bottles wouldn't be bumped or broken or others would not be punctured by sharps.).
- Snacks may not be shared with peers in the classroom and should be an appropriate type of carbohydrate.
- Students are expected to test and treat symptoms in class in the least disruptive manner possible. A nearby staff member should be notified immediately if a student becomes ill or feels they may need assistance. **Please do not hesitate to ask for assistance.**

These guidelines apply to all school related activities. Because of the potential harm to self or others that could arise, infractions of these guidelines will be referred for disciplinary action.

Student Signature

Date

Parent Signature

Date



Texas City Independent School District

1700 Ninth Avenue North, P.O. Box 1150, Texas City, Texas 77592-1150

Physician's Authorization for Student Self-Management of Diabetes

I have instructed _____ in the proper self-management of diabetes, including:

(Student's name)

Physician's initials:

- _____ Blood glucose testing
- _____ Insulin administration
- _____ Emergency treatment, including the use of fast acting carbohydrates and Glucagons.

This patient has been instructed in related safety precautions including the proper disposal of sharps and blood-soiled items.

I have completed and attached a ***Diabetic Management and Treatment Plan***, which includes physician directives for:

Physician's initials:

- _____ Blood glucose testing
- _____ Urine ketone testing
- _____ Appropriate response to abnormal blood sugar levels
- _____ Diabetic medications including Insulin (if applicable at school) and Glucagon.

Please initial one of the two choices below:

_____ In my professional opinion, this student should be allowed to carry diabetic supplies, including lancets and syringes, on his/her person, as well as to self-administer and manage diabetes testing and treatment while at school or school related events.

_____ In my professional opinion this student should **NOT** be allowed to carry diabetic equipment on his/her own person while at school or school related events.

Physician's Signature

Date

Printed Physician's Name

Physician's Phone Number

I agree with the physician's recommendations as noted above and have informed my child.

Parent's Signature

Date



Texas City Independent School District

1700 Ninth Avenue North, P.O. Box 1150, Texas City, Texas 77592-1150

Diabetes Medical Treatment Plan

This plan should be completed by the student's personal health care team and parents/guardian. It should be reviewed with relevant school staff and copies should be kept in a place that is easily accessed by the school nurse, trained diabetes personnel, and other authorized personnel.

Effective Dates: _____

Student's Name: _____

Date of Birth: _____ Date of Diabetes Diagnosis: _____

Grade: _____ Homeroom Teacher: _____

Physical Condition: Diabetes type 1 Diabetes type 2

Contact Information

Mother/Guardian: _____

Address: _____

Telephone: Home _____ Work _____ Cell _____

Father/Guardian: _____

Address: _____

Telephone: Home _____ Work _____ Cell _____

Student's Doctor/Health Care Provider:

Name: _____

Address: _____

Telephone: _____ Emergency Number: _____

Other Emergency Contacts:

Name: _____

Relationship: _____

Telephone Home _____ Work _____ Cell _____

Notify parents/guardian or emergency contact in the following situations: _____

Blood Glucose Monitoring

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

Usual times to check blood glucose _____

Times to do extra blood glucose checks (*check all that apply*)

- Before exercise
- After exercise
- When student exhibits symptoms of hyperglycemia
- When student exhibits symptoms of hypoglycemia
- Other (explain): _____

Can student perform own blood glucose checks? Yes No

Exceptions: _____

Type of blood glucose meter student uses: _____

Insulin

Usual Lunchtime Dose

Base dose of Humalog/Novolog /Regular insulin at lunch (circle type of rapid-/short-acting insulin used) is _____ units or does flexible dosing using _____units/ _____grams carbohydrate.

Use of other insulin at lunch: (circle type of insulin used): intermediate/NPH/lente _____ units or basal/Lantus/Ultralente _____ units.

Insulin Correction Doses

Parental authorization should be obtained before administering a correction dose for high blood Glucose levels. Yes No

_____ Units if blood glucose is _____ to _____ mg/dl

_____ Units if blood glucose is _____ to _____ mg/dl

_____ Units if blood glucose is _____ to _____ mg/dl

_____ Units if blood glucose is _____ to _____ mg/dl

_____ Units if blood glucose is _____ to _____ mg/dl

Can student give own injections? Yes No

Can student determine correct amount of insulin? Yes No

Can student draw correct dose of insulin? Yes No

Parents are authorized to adjust the insulin dosage under the following circumstances: _____

For Students with Insulin Pumps

Type of pump: _____ Basal rates: _____ 12 am to _____
_____ _____ to _____
_____ _____ to _____

Type of insulin in pump: _____

Type of infusion set: _____

Insulin/carbohydrate ratio: _____ Correction factor: _____

Student Pump Abilities/Skills:

Needs Assistance

- | | | |
|---|------------------------------|-----------------------------|
| Count carbohydrates | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bolus correct amount for carbohydrates consumed | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Calculate and administer corrective bolus | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Calculate and set basal profiles | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Calculate and set temporary basal rate | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Disconnect pump | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Reconnect pump at infusion set | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Prepare reservoir and tubing | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Insert infusion set | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Troubleshoot alarms and malfunctions | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

For Students Taking Oral Diabetes Medications

Type of medication: _____ Timing: _____

Other medications: _____ Timing: _____

Meals and Snacks Eaten at School

Is student independent in carbohydrate calculations and management? Yes No

<i>Meal/Snack</i>	<i>Time</i>	<i>Food content/amount</i>
Breakfast	_____	_____
Mid-morning snack	_____	_____
Lunch	_____	_____
Mid-afternoon snack	_____	_____
Dinner	_____	_____

Snack before exercise? Yes No

Snack after exercise? Yes No

Other times to give snacks and content/amount: _____

Preferred snack foods: _____

Foods to avoid, if any: _____

Instructions for when food is provided to the class (e.g., as part of a class party or food sampling event):

Exercise and Sports

A fast-acting carbohydrate such as _____ should be available at the site of exercise or sports.

Restrictions on activity, if any: _____

Student should not exercise if blood glucose level is below _____ mg/dl or above _____ mg/dl or if moderate to large urine ketones are present.

Hypoglycemia (Low Blood Sugar)

Usual symptoms of hypoglycemia: _____

Treatment of hypoglycemia: _____

Glucagon should be given if the student is unconscious, having a seizure (convulsion), or unable to swallow.

Route _____, Dosage _____, site for glucagon injection: _____ arm, _____ thigh, _____ other.

If glucagon is required, administer it promptly. Then, call 911 (or other emergency assistance) and the parents/guardian.

Hyperglycemia (High Blood Sugar)

Usual symptoms of hyperglycemia: _____

Treatment of hyperglycemia: _____

Urine should be checked for ketones when blood glucose levels are above _____ mg/dl.

Treatment for ketones: _____

Supplies to be Kept at School

_____ Blood glucose meter, blood glucose test strips, batteries for meter

_____ Lancet device, lancets, gloves, etc.

_____ Urine ketone strips

_____ Insulin pump and supplies

_____ Insulin pen, pen needles, insulin cartridges

_____ Fast-acting source of glucose

_____ Carbohydrate containing snack

_____ Glucagon emergency kit

This Diabetes Medical Treatment Plan has been approved by

_____ Date
Student's Physician/Health Care Provider

I give permission to the school nurse, trained diabetes personnel, and other designated staff members of _____ school to perform and carry out the diabetes care tasks as outlined by _____'s Diabetes Medical Treatment Plan. I also consent to the release of the information contained in this Diabetes Medical Treatment Plan to all staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety.

Acknowledged and received by:

_____ Date
Student's Parent/Guardian

_____ Date
Student's Parent/Guardian

(For School Use Only)

Plan has been reviewed by the following campus representatives:

Relationship to Student	Printed Name	Signature	Date
School Nurse			
School Administrator			
School Administrator			
Unlicensed Diabetes Care Assistant			
Classroom Teacher			



Authorization for Administration of Diabetes Management and Care Services by Unlicensed Diabetes Care Assistant

Information to Parents:

The health and safety of each student is always of paramount importance to every TCISD employee. The District is committed to providing a high level of care to meet any special medical needs students may exhibit.

To help carry out that commitment, TCISD ensures that a Registered Nurse is assigned to each campus. The 79th Texas Legislature, through House Bill 984, amended the Health and Safety Code to provide more specific requirements for the provision of diabetes management and care services to students in public schools who seek care for the student's diabetes while at school.

The school, in conjunction with the parent, will develop for each student who seeks care for diabetes at school an Individualized Health Plan that will specify the diabetes management and care services the student requires at school.

Traditionally, the school nurse has provided any medical care students might require at school. Under HB 984, each school also must train other employees to serve as Unlicensed Diabetes Care Assistants who can provide diabetes management and care services if a nurse is not available when a student needs such services.

Such services include the administration of insulin, or in an emergency, Glucagon. TCISD has trained staff at each school to provide such services. HB 984 further specifies that an Unlicensed Diabetes Care Assistant exercises his or her judgment and discretion in providing diabetes care services and that nothing in the statute limits the immunity from liability afforded to employees under section 22.0511 of the Texas Education Code.

Under HB 984, an Unlicensed Diabetes Care Assistant may only administer diabetes care and management services if the student's parent/guardian authorizes an Unlicensed Diabetes Care Assistant to assist the student and confirms his or her understanding that an Unlicensed Diabetes Care Assistant is immune from liability for civil damages under section 22.0511 of the Texas Education Code.

Please initial the appropriate box below to indicate your preference:

YES

Agreement for Services: I authorize an Unlicensed Diabetes Care

Assistant to provide diabetes management and care services to my child at school. I understand that an Unlicensed Diabetes Care Assistant is immune from liability for civil damages under section 22.0511 of the Texas Education Code.

NO

I DO NOT authorize an Unlicensed Diabetes Care Assistant to provide diabetes management and care services to my child at school.

Please initial below if your child will manage his/her diabetes independently while at school:

YES

My child can manage his/her diabetes independently and will not seek assistance for his/her diabetes while at school. I understand the school nurse will provide emergency care as needed. This information will be shared with school district personnel as needed.

Please initial below if you would like your child's classmates to be informed of your child's diabetes:

YES

I request that my child's classmates be informed that my child has diabetes, and given age-appropriate instruction regarding diabetes care, so that they understand the importance of symptoms and the types of intervention that may occur in the classroom.

Student's Name *(Please Print)*

School

Signature of Parent/Guardian

Date Signed



Diabetic Health Care Plan

To be Completed by child's School Nurse

Student's Name: _____ Date: _____ School: _____
Grade _____ Date of Birth: _____ Student ID #: _____
Homeroom Teacher: _____
Comments: _____

Health Action Plan

Daily Snacks

- Snack times: _____
- Does the student carry snacks with him/her? _____
- Location of snacks at school: _____

Blood Sugar Test

- Time: _____ Location: _____

Insulin injection

- Does the student have insulin injections at school? _____
- Time: _____ Location: _____
- Does the student carry his/her own supplies? _____
- Location at school? _____

Other Plan Items

Daily Time Schedule: (include snack times, recess, lunch, insulin injection times, etc.) _____

Additional Information

Concurrent illness or disability? _____

Social/Emotional Factors: _____

Concurrent Medications? _____ Allergies? _____

Dietary Concerns/restrictions? _____ **Contact**

Information

Parent/Guardian's Name(s): _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____ Home

Phone: _____ Work Phone: _____ Cell Phone: _____ Address: _____

Emergency Contact: _____ Phone: _____ Primary

Care Physician: _____ Phone: _____ Specialty

MD: _____ Phone: _____

Contingency Plan when unable to contact parent in emergency: (i.e. order to call above numbers) _____

Disaster kit at school? _____ If so, where is it located? _____

Print Name	Signature	Relationship to Student	Date

****Note: Parent MUST sign this form.



Individualized Health Plan (Off-Campus Activity Sheet)

I. Identifying Information

- Student's Name _____
- School _____
- Nurse _____
- Date of Birth _____
- Age _____
- Grade _____
- Classroom Teacher _____

- Mother's Name _____
- Address _____
- Home Phone # _____
- Work Phone # _____
- Cell Phone # _____

- Father's Name _____
- Address _____
- Home Phone # _____
- Work Phone # _____
- Cell Phone # _____

- Child's Physician _____
- Physician's Phone # _____
- Physician's Pager # _____

II. Medical Information

- Condition: Type I Diabetes
- Complications:
 1. **Hypoglycemia** (low blood glucose)
 - Mild/moderate symptoms: shaky, sweaty, hungry, sleepy, dizzy, disoriented, and/or lethargic
 - Severe symptoms: inability to swallow, seizure or convulsions, and/or unconsciousness
 2. **Hyperglycemia** (high blood glucose)
 - Mild/moderate symptoms: thirst, frequent urination, nausea, blurry vision, and/or fatigue
 - Severe symptoms: fruity breath odor, nausea, vomiting, stomach pain, and/or deep breathing and sleepiness
- Recommended Actions:
 - Contact parent(s)
 - Contact school nurse
 - Contact emergency personnel if symptoms are severe

SECTION VII

Severe Allergies and Treatment Plan

The following procedures are in accordance with the state-developed *Guidelines for the Care of Students with Food Allergies At-Risk for Anaphylaxis*.

REQUEST FOR FOOD ALLERGY INFORMATION

This form allows you to disclose whether your child has a food allergy or severe food allergy that you believe should be disclosed to the District in order to enable the District to take necessary precautions for your child's safety.

"Severe food allergy" means a dangerous or life-threatening reaction of the human body to a food-borne allergen introduced by inhalation, ingestion, or skin contact that requires immediate medical attention.

Please list any foods to which your child is allergic or severely allergic, as well as the nature of your child's allergic reaction to the food.

Food:	Nature of allergic reaction to the food:

The District will maintain the confidentiality of the information provided above and may disclose the information to teachers, school counselors, school nurses, and other appropriate school personnel only within the limitations of the Family Educational Rights and Privacy Act and District policy. [See FL]

Student name: _____ Date of birth: _____

Grade: _____

Parent/Guardian name: _____

Work phone: _____ Home phone: _____

Parent/Guardian Signature: _____ Date: _____

Date form was received by the school: _____



Texas City Independent School District

1700 Ninth Avenue North, P.O. Box 1150, Texas City, Texas 77592-1150

Dear Parent or Guardian:

You have disclosed that your child has a severe food allergy. The District requires additional information in order to take necessary precautions for your child's safety and to authorize treatment of your child in the event of an allergic reaction at school or at a school-related activity. Attached to this letter are the following forms:

1. Request for the Administration of Medication at School
2. Authorization to Secure Emergency Medical Treatment of a Student
3. Authorization for Self-Administration of Asthma and/or Anaphylaxis Medication
4. Statement Regarding Meal Substitutions or Modifications and signed by your child's Doctor.
5. Food Allergy & Anaphylaxis Emergency Care Plan (FARE)

Please have your physician or other licensed health-care provider complete these forms and return them to the office as soon as possible.

Sincerely,

Campus Nurse



Texas City Independent School District

1700 Ninth Avenue North, P.O. Box 1150, Texas City, Texas 77592-1150

STATEMENT REGARDING MEAL SUBSTITUTIONS OR MODIFICATIONS

Note: Information regarding accommodating children with special dietary needs can be found on the Texas Department of Agriculture Web site at <http://www.squaremeals.org/Portals/8/files/ARM/Section%2013-Accommodating%20Children%20with%20Special%20Dietary%20Needs.pdf>.

The United States Department of Agriculture regulations require substitutions or modifications in school meals for children whose disabilities restrict their diets. If a physician or other licensed health-care provider determines that a child's food allergies may result in severe, life-threatening (anaphylactic) reactions, then the child's condition will meet the definition of a disability, and the prescribed substitutions must be made by the District. In order to do so, the school nutrition program must receive a signed statement by the physician or other licensed health-care provider containing the following information:

The child's food allergy that constitutes a disability: _____

An explanation of why the disability restricts the child's diet: _____

The major life activity affected by the disability: _____

The food(s) to be omitted from the child's diet: _____

The food or choice of foods that must be substituted: _____

Physician Information:

Name: _____ Address: _____

Phone Number: _____

Physician Signature: _____ Date: _____

For Office Use Only:

Date form was received by the school: _____

Student name: _____ Date of birth: _____

Grade: _____



Texas City Independent School District

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INDIVIDUALIZED ALLERGY HEALTH-CARE PLAN

Note: If applicable, a student's individualized health-care plan must be coordinated with his or her Section 504 plan. [See FB for information regarding the application of Section 504 of the Rehabilitation Act to students who qualify for individualized health-care plans.]

Student name: _____ Date of birth: _____

Grade: _____

Primary health concerns/diagnoses: _____

Secondary health concerns/diagnoses: _____

Treating physician(s) information:

Name: _____ Address: _____

Phone Number: _____

Name: _____

Address: _____

Phone Number: _____

Name: _____ Address: _____

Phone Number: _____

Current medications* [see FFAC]:

*Attach the Request for the Administration of Medication at School and/or the Authorization for Self-Administration of Asthma and/or Anaphylaxis Medication, found at FFAC(EXHIBIT), as necessary.

Medical equipment:

Diagnosis:	Assessment:	Goal:	Implementation / Intervention**:	Anticipated outcome:	Evaluation:

**Attach an emergency health plan related to student's diagnosis, if necessary.

Effective date: _____

Parent's signature: _____ Date: _____

Nurse's signature: _____ Date: _____



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Authorization for Administration of Prescribed Allergy Medication

Name of Student: _____ Birthdate: _____

School: _____ School Year: _____ Grade: _____

Medical Condition	Medication Strength	Dose	Time	Route	Side Effects Possible
1.					
2.					
3.					

Other Considerations/Directions: _____

Start Date: _____ Stop Date: _____

(All authorizations expire at the end of the school year.)

- Student is knowledgeable about the medication and how to administer it.
- Student has the skills to safely possess and use medication.
- Student may self-administer the medication. (Not applicable for controlled substances.)

 Print or Type Name of Physician/Licensed Prescriber

 Signature

 Clinic Address

 Phone Number

 Date

Parent/Guardian Authorization - Please initial the following:

_____ I request that the above medication(s) be given during school hours as ordered by my child's physician/licensed prescriber. I also request the medication(s) be given on field trips, as prescribed.

_____ I release school personnel from liability in the event adverse reactions result from taking the medication(s).

_____ I will notify the school of any change in the medication(s), (e.g. medication change, dosage change, medication is discontinued, etc.)

_____ I give permission for the school nurse to communicate with my child's teachers about the student's health condition(s) and the action of the medication(s).

_____ I give permission for the school nurse to consult with my child's physician/licensed prescriber regarding any questions that arise with regard to the listed medication(s) or medical condition(s) being treated by the medication(s).

_____ I give permission for the medication(s) to be given by designated personnel as delegated by the school nurse.

_____ My son/daughter may self-administer his/her allergy medication(s). (Not applicable for controlled substances, such as Ritalin, Dexedrine, Codeine, etc.)

_____ Date

_____ Parent/Guardian Signature

_____ Relationship to Student

Note: Medication must be supplied in the original prescription bottle and the container (not the box) must be properly labeled with the prescription/pharmacy label with the student's name, type of medication, dosage, route and time noted.



FARE
Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergy to: _____

Weight: _____ lbs.

Asthma: Yes (higher risk for a severe reaction) No








For a suspected or active food allergy reaction:

PLACE
STUDENT'S
PICTURE
HERE

FOR ANY OF THE FOLLOWING

SEVERE SYMPTOMS

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

			
LUNG	HEART	THROAT	MOUTH
Short of breath, wheezing, repetitive cough	Pale, blue, faint, weak pulse, dizzy	Tight, hoarse, trouble breathing/swallowing	Significant swelling of the tongue and/or lips
			OR A COMBINATION of mild or severe symptoms from different body areas.
SKIN	GUT	OTHER	
Many hives over body, widespread redness	Repetitive vomiting or severe diarrhea	Feeling something bad is about to happen, anxiety, confusion	





NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. Use Epinephrine.

- 1. INJECT EPINEPHRINE IMMEDIATELY.**
- 2. Call 911.** Request ambulance with epinephrine.
 - Consider giving additional medications (following or with the epinephrine):
 - » Antihistamine
 - » Inhaler (bronchodilator) if asthma
 - Lay the student flat and raise legs. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
 - If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
 - Alert emergency contacts.
 - Transport student to ER even if symptoms resolve. Student should remain in ER for 4+ hours because symptoms may return.

NOTE: WHEN IN DOUBT, GIVE EPINEPHRINE.

MILD SYMPTOMS

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

	
NOSE	MOUTH
Itchy/runny nose, sneezing	Itchy mouth
	
SKIN	GUT
A few hives, mild itch	Mild nausea/discomfort

↓ ↓ ↓

- 1. GIVE ANTIHISTAMINES, IF ORDERED BY PHYSICIAN**
- Stay with student; alert emergency contacts.
- Watch student closely for changes. If symptoms worsen, **GIVE EPINEPHRINE.**

MEDICATIONS/DOSES

Epinephrine Brand: _____

Epinephrine Dose: 0.15 mg IM 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

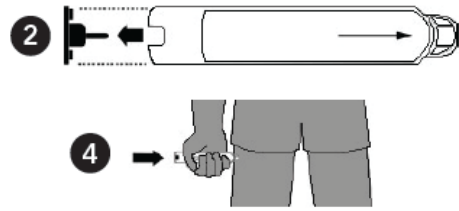
Other (e.g., inhaler-bronchodilator if asthmatic): _____

PARENT/GUARDIAN AUTHORIZATION SIGNATURE _____ DATE _____ PHYSICIAN/HCP AUTHORIZATION SIGNATURE _____ DATE _____



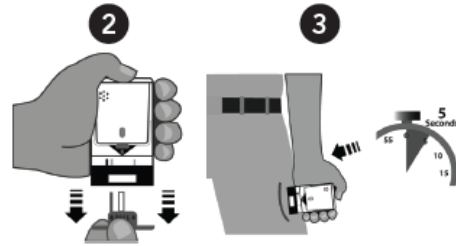
EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

1. Remove the EpiPen Auto-Injector from the plastic carrying case.
2. Pull off the blue safety release cap.
3. Swing and firmly push orange tip against mid-outer thigh.
4. Hold for approximately 10 seconds.
5. Remove and massage the area for 10 seconds.



AUVI-Q™ (EPINEPHRINE INJECTION, USP) DIRECTIONS

1. Remove the outer case of Auvi-Q. This will automatically activate the voice instructions.
2. Pull off red safety guard.
3. Place black end against mid-outer thigh.
4. Press firmly and hold for 5 seconds.
5. Remove from thigh.



ADRENACLICK®/ADRENACLICK® GENERIC DIRECTIONS

1. Remove the outer case.
2. Remove grey caps labeled "1" and "2".
3. Place red rounded tip against mid-outer thigh.
4. Press down hard until needle penetrates.
5. Hold for 10 seconds. Remove from thigh.



OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat student before calling Emergency Contacts. The first signs of a reaction can be mild, but symptoms can get worse quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____

PHONE: _____

NAME/RELATIONSHIP: _____

PHONE: _____

PARENT/GUARDIAN AUTHORIZATION SIGNATURE _____

DATE _____



Texas City Independent School District
1700 Ninth Avenue North, P.O. Box 1150, Texas City, Texas 77592-1150

ANAPHYLAXIS INCIDENT REPORT FORM

Student name: _____ Date of birth: _____

Campus: _____ Grade: _____

Date of incident: _____

If known, the location and source of the allergen exposure:

Emergency action taken (attach additional pages if more space is needed):

Were emergency services contacted?

Yes No

Was an epinephrine auto-injector used?

Yes No

If yes, who administered the epinephrine?

Student (self-administration)

Staff (provide name and position title): _____

Other: _____

Are any changes to procedures recommended?

Signature: _____ Date: _____

Received By: _____ Date: _____

SECTION VIII

Medical Excuses for Physical Education/Recess

A written excuse is required if a child is not to participate in physical education. If the child is to be excused more than three (3) consecutive days, a physician's statement is required. A child who has been excused from physical education will also be excused from recess. Examples for exclusion from physical education/ recess by a physician: sutures, fractures (casts), or post-surgery. In order to return to physical education/recess, a student must have a written release from their physician (not a parent).

All physicians' notes must be turned in to the nurse's office.

SECTION IX

Policies related to student welfare and health services can be accessed at www.tcisd.org:

Relevant Texas City ISD Policies

FFAE
FFAD
FFAF
FFA
FFB