

*Cover Page: 2017-2018*

Dear Parent/Guardian:

Welcome to the Indiana Academy!! We look forward to getting to know each of you. The next several pages include the health related requirements for your student. Please be thorough when completing your child’s health forms…do not leave any blanks. Below you will find a summary of the items required for your junior residential student, as well as important due dates for each item:

|  |  |  |
| --- | --- | --- |
|  | **JUNIOR HEALTH REQUIREMENTS** | **DUE DATE** |
| 1. | **Required: Pages 1 thru 6** of the junior health packet are to be completed by the parent/guardian (Form B pages 1-6).   * Student will need to complete & sign the top of page 6. * Parent/guardian will need to complete & sign the bottom of page 6. | July 21, 2017 |
| 2. | **Required:** Please provide a copy of your child’s **Medical & Prescription Card (s)**, both front & back.   * If you have a separate card for prescriptions please include of front & back copy of it too. | July 21, 2017 |
| 3. | **Required:** Please supply a copy of your child’s **Immunization Record.**   * See “FYI Form B Page 4” for a complete list of required & recommended vaccinations. | July 21, 2017 |
| 4. | **IF APPLICABLE: Page 7** for prescription medication.   * This page is ONLY required if your child has prescription medication (such as: oral meds, birth control pills, inhalers, insulin, nasal sprays & topical meds). * Consent for self administration of non-controlled prescription medication is required by both the parent/guardian (on page 5) and the prescriber (on page 7). Your child will not be permitted to self administer his/her medication until both consents are on file. | July 21, 2017 |
| 5. | **IF APPLICABLE: Action Plans (pages 8 – 11).**   * Page 8 (Asthma Action Plan) – this page is required if your child has a diagnosis of Asthma. * Page 9 (Diabetes Action Plan) – this page is required if your child has a diagnosis of Diabetes. * Page 10 (Seizure Action Plan) – this page is required if your child has a diagnosis of Seizure Disorder/Epilepsy. * Page 11 (Severe Allergy/Anaphylaxis Action Plan) – this page is required if you child has severe/life threatening allergies. | July 21, 2017 |
| 6. | **IF APPLICABLE: Page 12** for Religious Exemption to vaccinations.   * A written statement from the parent/guardian is required if your child has a religious exemption to any vaccine. * You can use the top of page 12 or provide a statement of your own. | July 21, 2017 |
| 7. | **IF APPLICABLE: Page 12** for Medical Exemption to vaccinations.   * A written statement from your physician is required if your child has a medical exemption to any vaccine. * Your physician can use the bottom of page 12 or provide a statement of his/her own. | July 21, 2017 |

The due dates for the above items are listed in the right column above. If your child is on prescription medication **OR** has asthma, diabetes, seizure disorder or severe/life threatening allergies, please plan ahead and schedule an appointment with your physician to complete the appropriate health packet pages or call the office to see if the physician will complete the form (s) without being seen.

Please review the immunization requirements/recommendations (FYI Form B page 4) as the Indiana State Department of Health has made some changes.

Please do not hesitate to let us know if you have any questions or concerns. Thanks so much and we look forward to seeing each of you this summer!

Sincerely,

Tina Brinkman, RN Nikki Al Khatib, RN

Coordinator of Healthcare Services School Nurse

[cbrinkma@bsu.edu](mailto:cbrinkma@bsu.edu) [nalkhatib@bsu.edu](mailto:nalkhatib@bsu.edu)

(765) 285-7360 (765) 285-7360

(765) 285-0063 fax (765) 285-0063 fax

**

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**STUDENT INFORMATION - residential & non-residential students:**

**Student’s Legal Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Goes By:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Grade Level: \_\_\_\_\_ 11th \_\_\_\_\_ 11th NECP \_\_\_\_\_ 11th International

\_\_\_\_\_ 12th \_\_\_\_\_ 12th NECP \_\_\_\_\_ 12th International \_\_\_\_\_ Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address City State Zip

Student Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Student Gender: \_\_\_\_\_Male \_\_\_\_\_Female

Student Cell Phone #: (\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_ Lives With: \_\_\_\_\_Both Parents \_\_\_\_\_Guardian

\_\_\_\_\_Father \_\_\_\_\_ Other

\_\_\_\_\_Mother

**CONTACT INFORMATION FOR HEALTH INFORMATION – residential & non-residential students:**

*Please list only those contact names/emails/phone numbers we should use to provide health/medical information on your student*

*Please list only those individuals who legally have the right to receive health/medical information on your student*

**Contact #1 Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Relationship to student:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is address same as student: \_\_\_\_\_Yes \_\_\_\_\_No

Cell Phone #: (\_\_\_) \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_ Land Line #: (\_\_\_) \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_ Work #: (\_\_\_) \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_

Email Address: (1) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (2)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Contact #2 Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Relationship to student:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is address same as student: \_\_\_\_\_Yes \_\_\_\_\_No

Cell Phone #: (\_\_\_) \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_ Land Line #: (\_\_\_) \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_ Work #: (\_\_\_) \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_

Email Address: (1) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (2)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Contact #3 Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Relationship to student:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is address same as student: \_\_\_\_\_Yes \_\_\_\_\_No

Cell Phone #: (\_\_\_) \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_ Land Line #: (\_\_\_) \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_ Work #: (\_\_\_) \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_

Email Address: (1) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (2)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*CC: Tina Brinkman, RN/Nikki Al Khatib, RN*



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**Student’s Legal Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DELEGATION OF AUTHORITY TO CONSENT TO HEALTHCARE – residential & non-residential students:**

*This page gives the Indiana Academy/Ball State University authorization to consent to health care services, as necessary, for those students and other minor children listed below, in the absence of the parent/guardian.*

**Student/Minor Children Information:**

|  |  |  |  |
| --- | --- | --- | --- |
| Student Name (s) | Birth Date | Allergies | Special Medical Problems |
|  |  |  |  |
|  |  |  |  |
| Other Minor Children Name (s) | Birth Date | Allergies | Special Medical Problems |
|  |  |  |  |
|  |  |  |  |

I, the parent/guardian, of the above named children, hereby delegate authority to consent to all health care in my absence (pursuant to IC 16-36-1-6)

**To:**

*The Indiana Academy for Science, Mathematics, and Humanities/Ball State University*

*Ball State University – Wagoner Complex – 301 N. Talley*

*Muncie, IN 47306*

*(765) 285-8125*

**From:**

*June 1, 2017 to July 1, 2018*

**Parent/Guardian Signature (s):**

Parent Name (1): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_ (2):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature (s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Witness Signature:**

Witness Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **The parent/guardian is responsible for all medical**

**expenses incurred while at the Indiana Academy for**

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Science, Mathematics, and Humanities.**

City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*CC: Tina Brinkman, RN/Nikki Al Khatib, RN*



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**Student’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health Information – residential & non-residential students:**

*Please check “yes or no” to each and comment on all “yes” responses*

|  |  |  |  |
| --- | --- | --- | --- |
| **DO YOU CURRENTLY HAVE:** | **YES** | **NO** | **COMMENT/ ANSWER**  (if applicable) |
| Anxiety |  |  | *Medicine: \_\_\_\_Yes \_\_\_\_No* |
| Arthritis |  |  | *Type:* |
| Asthma |  |  | *Inhaler : \_\_\_\_Yes \_\_\_\_No*  *Nebulizer: \_\_\_\_Yes \_\_\_\_No* |
| Crohn’s Disease |  |  |  |
| Depression |  |  | *Medicine: \_\_\_\_Yes \_\_\_\_No* |
| Diabetes |  |  | *Insulin Pump: \_\_\_Yes \_\_\_ No*  *Date of Diagnosis:* |
| Eating Disorder |  |  | *Type:* |
| Epilepsy/Seizures |  |  | *Medicine: \_\_\_\_Yes \_\_\_\_No*  *Date of Diagnosis:* |
| Hearing Impairment |  |  | *\_\_\_\_ Left \_\_\_\_Right \_\_\_Both*  *Hearing Aids: \_\_\_Yes \_\_\_ No* |
| High or Low  Blood Pressure |  |  | *High: \_\_\_\_\_ Yes \_\_\_\_\_ No*  *Low : \_\_\_\_\_ Yes \_\_\_\_\_ No* |
| Insomnia |  |  | *Medicine: \_\_\_\_Yes \_\_\_\_No* |
| Irritable Bowel  Syndrome (IBS) |  |  |  |
| Mental Illness |  |  | *Medicine: \_\_\_\_Yes \_\_\_\_No* |
| Seasonal Allergies |  |  | *Season(s):* |
| Skin Disorder |  |  | *Type:* |
| Thyroid Disorder |  |  | *Medicine: \_\_\_\_Yes \_\_\_\_No*  *Type:* |
| Tuberculosis |  |  | *Medicine: \_\_\_\_Yes \_\_\_\_No*  *Date of Onset:*  *Date last chest x-ray:* |

|  |
| --- |
| **PLEASE LIST ANY *MEDICAL CONDITIONS*/*ISSUES***  **THAT WAS NOT LISTED IN THE LEFT COLUMN:** |
| 1) |
| 2) |
| 3) |
| 4) |
| 5) |
| 6) |
| 7) |
| 8) |
| 9) |
| 10) |

|  |  |
| --- | --- |
| **PLEASE LIST ALL *ALLERGIES & REACTIONS***  **(medication/food/environmental/etc)** | |
| **Allergic To:** | **Reaction:** |
| 1) |  |
| 2) |  |
| 3) |  |
| 4) |  |
| 5) |  |
| 6) |  |
| 7) |  |
| 8) |  |
| 9) |  |
| 10) |  |

**Over-the-Counter Medication – residential & non-residential students:**

*Please check “yes or no: for EACH medication indicating whether the IASMH can provide to your child as needed*

|  |  |  |  |
| --- | --- | --- | --- |
| **Over-the-Counter Medication** | **Indication** | **YES** | **NO** |
| Acetaminophen (equivalent to Tylenol) | Pain reliever & fever reducer |  |  |
| Antacid | Heartburn, sour stomach & indigestion |  |  |
| Antibiotic Ointment | First aid prophylaxis |  |  |
| Antihistamine (equivalent to Benadryl) | Cold/allergy symptoms, rash & itch |  |  |
| Cough Drops | Cough & throat irritation |  |  |
| Decongestant (non-sudafed) | Nasal & sinus congestion |  |  |
| Hydrocortisone Cream 1% | Temporary relief of itch |  |  |
| Hydrogen Peroxide | First aid prophylaxis |  |  |
| Ibuprofen (equivalent to Advil/Motrin) | Pain reliever, fever reducer & anti-inflammatory |  |  |
| Pink Bismuth Chew Tabs (equivalent to Pepto Bismol) | Upset stomach, indigestion, heartburn, nausea & diarrhea |  |  |

**Additional Information:**

*Please include any additional health information here or on a separate piece of paper*

*CC: Tina Brinkman, RN/Nikki Al Khatib, RN*

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**Student’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Physician Information – residential & non-residential students:**

Please list all physicians your child sees

**Primary Care Physician (Family Physician):**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Office #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Specialist (s):**

1. Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason for seeing this Specialist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason for seeing this Specialist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Information – residential students:**

1. Does your child have health insurance? \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ Pending

2. Name of Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Name of Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder’s DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_

4. Is there a separate card for prescriptions? \_\_\_\_\_ Yes \_\_\_\_\_ No

5. Does your child carry a copy of his/her insurance card? \_\_\_\_\_ Yes \_\_\_\_\_ No

6. Is there a co-pay for prescriptions? \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, how much is the co-pay? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. Is your child covered by more than 1 (one) insurance company? \_\_\_\_\_ Yes \_\_\_\_\_ No

***If you answered “yes” to question 7, please continue & answer questions 8 & 9 below***

8. Name of Secondary Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

9. Name of Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder’s DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_

**Pharmacy – residential students:**

*PLEASE READ THE PHARMACY INFORMATION BELOW & ANSWER ALL QUESTIONS*

|  |  |
| --- | --- |
| **Pharmacy Name:** | **Pharmacy Information:** |
| IU Health Ball State University Pharmacy  1500 N. Neely Avenue  Muncie, IN 47306  (765) 285-8431  *Hours of Operation*  *Monday: 8:00am – 4:30pm*  *Tuesday: 9:00am – 6:30pm*  *Wednesday: 9:00am – 6:30pm*  *Thursday: 8:00am – 4:30pm*  *Friday: 8:00am – 4:30pm*  *Saturday/Sunday: Closed* | * The BSU Pharmacy is located on campus. * The BSU Pharmacy accepts & files the majority of insurance plans, including Hoosier Healthwise/Medicaid plans. Therefore, **this is the ONLY pharmacy we will use during their hours of operation listed to the left (unless your insurance requires a specific pharmacy).** * Payment Options: **Bursar Account,** Cash, Check, Credit/Debit or Health Saving Account Card (bursar account will automatically be charged in the event your child does not have another means of payment available at the time needed). * BSU will mail you a bill for any medication placed on the bursar account. |

1. If your child needs prescription medication outside of the BSU Pharmacy hours listed above, please

indicate here which pharmacy you would like us to use:

\_\_\_\_\_\_\_\_\_\_ Walgreens Pharmacy – 2720 W. Jackson St. – Muncie, IN 47304 – (765) 287-8533

* *Walgreens will not accept payment over the telephone.*
* *Payment Options:* ***Express Pay****, Cash, Check, Credit/Debit Card or Health Savings Account Card.*
* *You can set up* ***Express Pay*** *by going to any Walgreen’s Pharmacy.*
* *https://www.walgreens.com/topic/help/pharmacyhelp/pharmacy\_help\_main.jsp#ExpressPay*

**\_\_\_\_ YES \_\_\_\_ NO *My child has been set up for Express Pay at Walgreens Pharmacy***

\_\_\_\_\_\_\_\_\_\_ CVS Pharmacy – 2729 W. Jackson St. – Muncie, IN 47304 – (765) 287-0074

* *CVS will not accept payment over the telephone.*
* *Payment Options: Cash, Check, Credit/Debit Card or Health Savings Account Card.*

*CC: Tina Brinkman, RN/Nikki Al Khatib, RN*



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**Student’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Prescription Medication – residential & non-residential students:**

|  |  |  |
| --- | --- | --- |
|  | **YES** | **NO** |
| Does your child take or use prescription medication on a routine or “as needed” basis?   * ***Examples includes: oral medication, birth control pills, insulin, pipens, inhalers, nasal sprays, eye/ear drops & topical creams/lotions/gels.*** |  |  |

* ***If you answered “yes” to the question above, please complete this entire page.***
* ***If you answered “no” to the above question, please skip this section and proceed to page 6.***

**PLEASE LIST ALL PRESCRIPTION MEDICATION INFORMATION HERE:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medication**  **(name/dosage/frequency)** | **Is this medication to be taken every day routinely or as needed**  **(✓)** | **Time of day medication is taken** | **Reason for medication** | **Parent consent for self administration**  **(✓)** |
| *Example: Singulair 10mg – 1 tablet daily*  *Example: ProAir – 2 puffs every 4 hours*  *Example: Retin A Topical – apply to face daily* | *✓ Routine \_\_\_\_ As Needed*  *\_\_\_\_Routine ✓ As Needed*  *✓ Routine \_\_\_\_ As Needed* | *AM*  *PM* | *Allergies*  *Asthma*  *Acne* | *✓*  *✓* |
| **1)** |  |  |  |  |
| **2)** |  |  |  |  |
| **3)** |  |  |  |  |
| **4)** |  |  |  |  |
| **5)** |  |  |  |  |
| **6)** |  |  |  |  |
| **7)** |  |  |  |  |
| **8)** |  |  |  |  |
| **9)** |  |  |  |  |
| **10)** |  |  |  |  |

***Please add any additional prescription medication on a separate piece of paper***

|  |  |  |
| --- | --- | --- |
|  | **YES** | **NO** |
| I, the parent/guardian, understand consent for self administration of the above prescription medication is required by both the parent/guardian and the prescribing healthcare provider?   * *Self administration only applies to “non-controlled” medication. Controlled medication is not permitted in student rooms and cannot be self administered.* * *For parent/guardian consent – please place a check mark (✓) in the “parent consent” column above for each medication that you give permission for self administration.* * *For healthcare provider consent – please take page 7 of this packet to the prescribing provider for completion.* * *Please review the “IASMH Medication Policy” on FYI Form B Page 4.* |  |  |
| ***THIS QUESTION IS FOR RESIDENTIAL STUDENTS ONLY:***  I, the parent/guardian, request that the Indiana Academy nurse’s office refill my child’s prescription medication when needed?   * *By answering “yes” to this question, you, the parent/guardian, are giving consent for the IASMH to refill your child’s prescription medication when needed.* * *By answering “no” to this question, you, the parent/guardian, are indicating that you will refill your child’s prescription medication and deliver to the nurse’s office when needed.*   **If you answered “yes” to this question, one of the following is required for us to refill the above medication (please check one):**  **\_\_\_\_\_\_\_\_\_\_** I, the parent/guardian will provide written prescriptions for each medication to be filled by the IASMH.  **\_\_\_\_\_\_\_\_\_\_** I, the parent/guardian will have my physician call in a refill to the IU Health BSU Pharmacy at  (765) 285-1079.  **\_\_\_\_\_\_\_\_\_\_** I, the parent/guardian, will call the IU Health BSU Pharmacy at (765) 285-1079 and ask the pharmacist to  transfer my child’s prescription medication from our home pharmacy to the BSU Pharmacy.  **Please provide your “home” pharmacy information here:**   * Pharmacy Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Pharmacy Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |

*CC: Tina Brinkman, RN/Nikki Al Khatib, RN*



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**Student’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Student Signature – residential & non-residential:**

|  |  |  |  |
| --- | --- | --- | --- |
|  | *This section is to be completed and signed by the student (residential/NECP/International)* | **YES** | **NO** |
| 1. | I, a student at the Indiana Academy, received and read the fact sheet regarding ***Concussion****.* I understand the risk of concussion and head injury, including the risks of continuing an activity/sport after a concussion or head injury (FYI Form B page 1)? IC 20-34-7 |  |  |
| 2. | I, a student at the Indiana Academy, received and read the fact sheet regarding ***Sudden Cardiac Arrest*** and understand the symptoms of sudden cardiac arrest (FYI Form B page 1)? IC 20-34-8 |  |  |
| 3. | I, a student at the Indiana Academy, received and read the ***Overview of the Prescription Medication Policy.*** I will ask questions if I do not understand the policy (FYI Form B page 4)? |  |  |

**Student Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent/Guardian Signature**

*This section is to be completed and signed by the parent/guardian*

|  |  |  |  |
| --- | --- | --- | --- |
| **\*** | **QUESTIONS 1 – 6: TO BE COMPLETED BY PARENT/GUARDIAN FOR ALL STUDENTS (residential, NECP & International):** | **YES** | **NO** |
| 1. | I, the parent/guardian, received and read both of the fact sheets regarding ***Concussion and Sudden Cardiac Arrest*** (FYI Form B page 2)? I understand the nature and risk of concussion and head injury, including the risks of continuing an activity/sport after a concussion or head injury, as well as the symptoms of sudden cardiac arrest? |  |  |
| 2. | I, the parent/guardian, received and read the ***Meningitis Fact Sheet*** (FYI Form B page 3)? |  |  |
| 3. | I, the parent/guardian, received and read the ***Overview of the Prescription Medication Policy*** (FYI Form B page 4)? |  |  |
| 4. | I, the parent/guardian, understand that I am responsible for submitting a complete and up-to-date copy of my child’s ***Immunization Record*** to the nurse’s office by the first day of class (FYI Form B page 4)? |  |  |
| 5. | I, the parent/guardian, understand that pertinent medical information on my child may be relayed to appropriate faculty/staff/administration? |  |  |
| 6. | I, the parent/guardian, give consent for my child to participate in & provide a blood donation during our IASMH blood drives (do not need consent for students 17 years old and older)? |  |  |
| **\*** | **QUESTIONS 7 – 11: TO BE COMPLTED BY PARENT/GUARDIAN FOR ALL 11TH & 12TH “RESIDENTIAL” STUDENTS:** | **YES** | **NO** |
| 7. | I, the parent/guardian, authorize & consent to treatment at the IU Health Ball State University Health Center or other urgent care facility for non-emergency health care needs, such as minor illness & Injury? |  |  |
| 8. | I, the parent/guardian, give consent for the Indiana Academy Nursing Staff to communicate with the Ball State University Health Center, verbally in person, by phone, fax or electronic mail, as needed in the best interest of the student.   * *This includes, but is not limited to: scheduling appointments, obtaining test results, obtaining healthcare instructions/recommendations.* |  |  |
| 9. | I, the parent/guardian, give permission for my student to self administer medication prescribed to him/her DURING the academic school year by the BSU Health Center, other urgent care facility, or primary care physician, ***in compliance with our school policy***? |  |  |
| 10. | I, the parent/guardian, understand I am responsible for all medical/prescription expenses incurred while my child is a student at the IASMH? |  |  |
| 11. | I, the parent/guardian, have enclosed a copy of my child’s ***Medical & Prescription Card (s)***, both front & back? |  |  |
| **\*** | **QUESTION 11: TO BE COMPLETED BY PARENT/GUARDIAN FOR ALL 11TH GRADE STUDENTS (residential, NECP & International):** | **YES** | **NO** |
| 12. | I, the parent/guardian, give permission to the IASMH Nursing Staff to enter my child’s immunizations into the ***Indiana State Department of Children & Hoosier Immunization Program (CHIRP)?***   * The information in the registry may be used to verify my child has received proper immunizations and to inform me or my child of my child’s immunization status or that an immunization is due according to recommended immunization schedules. * The CHIRP database is the method used by all school nurses in Indiana to report compliance, exemptions, and vaccine allergies. * The information in the registry may be available to the immunization data registry of another state, a Healthcare provider or a provider’s designee, a local health department, an elementary or secondary school, a child care center, the office of Medicaid Policy & Planning or a contractor of the office of Medicaid Policy & Planning, a licensed child placing agency, and a college or university. Other entities may be added to this list through amendment to I.C. 16-38-3. * Other than the immunization record/exemptions/vaccine allergies, the following information may be needed for CHIRP: student’s name, date of birth, address, phone number and parent/guardian name. |  |  |

**Parent/Guardian Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*CC: Tina Brinkman, RN/Nikki Al Khatib, RN*



*Page 7: 2017-2018*

**Student’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Physician/Provider Prescription Medication – residential & non-residential students:**

* *This page is required ONLY if your child has any prescription medication*
* *This page MUST be completed by the Prescribing Provider (not the parent/guardian)*
* *Prescription medication includes: oral medication including birth control pills, insulin, epipens, inhalers, nasal sprays, topical creams/lotions/gels & eye/ear drops*
* *All columns in the table below must be complete, as well as the physician/prescriber information below*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medication**  (name/dosage/route/frequency) | **As Needed?**  (please circle) | **Diagnosis** | **Consent for Self**  **Administration**  (please circle) | **Initials of**  **Physician/**  **Provider** |
| *Example: Singulair 10mg – 1 tablet po daily*  *Example: ProAir – Inhale 2 puffs po every 4 hrs PRN*  *Example: Retin A – apply topically to face daily* | YES or NO  YES or NO  YES or NO | *Allergies*  *Asthma*  *Acne* | YES or NO  YES or NO  YES or NO | *CB*  *CB*  *CB* |
| **1)** | YES or NO |  | YES or NO |  |
| **2)** | YES or NO |  | YES or NO |  |
| **3)** | YES or NO |  | YES or NO |  |
| **4)** | YES or NO |  | YES or NO |  |
| **5)** | YES or NO |  | YES or NO |  |
| **6)** | YES or NO |  | YES or NO |  |
| **7)** | YES or NO |  | YES or NO |  |
| **8)** | YES or NO |  | YES or NO |  |
| **9)** | YES or NO |  | YES or NO |  |
| **10)** | YES or NO |  | YES or NO |  |

**Physician/Prescriber #1:**

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Prescriber Initials: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office Email (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Physician/Prescriber #2:**

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Prescriber Initials: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office Email (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Physician/Prescriber #3:**

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Prescriber Initials: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office Email (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*CC: Tina Brinkman, RN/Nikki Al Khatib, RN*

**ASTHMA ACTION PLAN – residential & non-residential students:**

**ASTHMA ACTION PLAN IS REQUIRED ONLY IF YOUR CHILD HAS A CURRENT DIAGNOSIS OF ASTHMA** *Page 8 – 2017-2018*

**TO BE COMPLETED BY PARENT/GUARDIAN:**

Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade Level: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: (Home) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Work) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Cell) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Asthma Care Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Office Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Office Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office Email (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School Nurse Email: [cbrinkma@bsu.edu](mailto:cbrinkma@bsu.edu) (Tina Brinkman) School Nurse Phone: (765) 285-7360 School Nurse Fax: (765) 285-0063

|  |  |
| --- | --- |
| **TO BE COMPLETED BY**  **ASTHMA CARE PROVIDER:** | ***RESCUE (quick-relief) MEDICATION***: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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|  | **MONITORING** | **TREATMENT** | | |
| **RED** | RED ZONE: DANGER SIGNS   * Very short of breath, or * Rescue medications have not helped, or * Cannot do usual activities, or * Symptoms are same or get worse after 24 hours in Yellow Zone   RED ZONE: EMERGENCY SIGNS   * Lips & fingernails are blue or gray * Trouble walking & talking due to shortness of breath * Loss of consciousness | * Give rescue medications:  2  4  6 puffs (1 min between puffs) or 1 nebulizer treatment. * **Call parent and/or Asthma Care Provider.** * **Call 911 NOW if:**  1. Unable to reach medical care provider after arriving in the red zone. 2. Child is struggling to breathe & there is no improvement after taking Albuterol. 3. May repeat rescue medication every 10 minutes if symptoms do not improve, until medical assistance has arrived or you are at the emergency department. | | |
| **YELLOW** | YELLOW ZONE: CAUTION   * Cough, wheeze, chest tightness, or shortness of breath, or * Waking at night due to asthma, or * Can do some, but not all, usual activities | * Continue daily controller medications. * Give rescue medications:  2  4  6 puffs (1 min between puffs) or 1 nebulizer treatment every 4 hours as needed. * Wait 10 minutes and recheck symptoms. * **If not better, go to RED ZONE.** * **If symptoms improve, may return to class or normal activity, or \_\_\_\_\_\_\_\_\_\_\_\_**   **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**   * **Parent/School Nurse:** If needed, coordinate rescue medications to be given every 4 hours for  2  3 days, if symptoms remain improved. * If symptoms are not gone after  2  3 days, move to the **RED ZONE**. | | |
| GREEN | GREEN ZONE: WELL   * No cough, wheeze, chest tightness, or shortness of breath during the day or night. * Can do usual activities | MEDICATION: | HOW MUCH” | WHEN:  **Before Exercise:**   Recess   PE/Sports  *(not to exceed every 4 hours)* |
|  |  | DAILY CONTROLLER MEDICATION:  1. | HOW MUCH: | WHEN: |
|  |  | 2. |  |  |
|  |  | 3. |  |  |

|  |
| --- |
|  Administer medication as instructed above   Student has been instructed on proper use of all his/her asthma medications, and in my opinion, the student can carry & use his/her inhaler at  school   Student needs supervision or assistance to use his/her inhaler medication   Student should **NOT** carry his/her inhaler while at school  Have student use spacer with inhaler medication  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **ASTHMA CARE PROVIDER SIGNATURE PLEASE PRINT PROVIDER NAME DATE**  I give permission for the school nurse and any pertinent staff caring for my child to follow this plan, administer medication and care for my child, contact the asthma care provider if necessary and for this form to be faxed/emailed to my child’s school or be shared with school staff per FERPA guidelines. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **PARENT/GUARDIAN SIGNATURE DATE** |

*CC: Tina Brinkman, RN/Nikki Al Khatib, RN*

**DIABETES ACTION PLAN – residential & non-residential students:**

**DIABETES ACTION PLAN IS REQUIRED ONLY IF YOUR CHILD HAS A CURRENT DIAGNOSIS OF DIABETES** *Page 9 – 2017-2018*

**TO BE COMPLETED BY PARENT/GUARDIAN:**

Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade Level: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: (Home) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Work) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Cell) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diabetes Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Office Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Office Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office Email (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School Nurse Email: [cbrinkma@bsu.edu](mailto:cbrinkma@bsu.edu) (Tina Brinkman) School Nurse Phone: (765) 285-7360 School Nurse Fax: (765) 285-0063

|  |  |
| --- | --- |
| **TO BE COMPLETED BY**  **DIABETES CARE PROVIDER:** |  Type 1  Type 2 Insulin Pump?:  Yes  No ID Bracelet or Necklace?:  Yes  No  Blood Glucose Target Range: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Type of Insulin Used: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |
| --- |
| **Current Insulin Treatment & Monitoring:** Can self-prepare insulin?  Yes  No  NA Can inject insulin on own?  Yes  No  NA  Needs assistance w/ preparation & injection of insulin?  Yes  No  NA Able to perform self-blood glucose testing?  Yes  No  Needs assistance with blood glucose testing?  Yes  No  **Blood Sugar Testing Times:**  Before all meals  Before snacks  At bedtime  Before gym/recess  After gym/recess   If ill/sick  If feels/acts hypoglycemic  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Insulin Calculation for Meals/Snacks:** Breakfast: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ AM Snack: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Lunch: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PM Snack: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dinner: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Comments/Special Instructions:  **Exercise/Sport Activity:** May participate in PE classes?  Yes  No May participate in after school sports?  Yes  No  Student carries \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ for treatment of LOW BLOOD GLUCOSE if *conscious.*  Student carries \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ for treatment of LOW BLOOD GLUCOSE if *unconscious.*  Snack should be eaten if blood glucose is under \_\_\_\_\_\_\_. Exercise should be delayed if blood glucose is **higher** than \_\_\_\_\_\_ or **lower** than \_\_\_\_\_  **Treatment of Low Blood Sugar (Hypoglycemia):** Hypoglycemia is a blood sugar less than \_\_\_\_\_\_\_\_.  Student’s symptoms of low blood sugar:  Trembling  Shaky  Sweaty  Pale  Headache  Weak  Dizzy  Irritable   Confused  Restless  Combative  Incoherent (as if drunk)  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Treatment for **conscious** student with low blood sugar (able to swallow):  Give immediate sugar source (4 glucose tabs, ½ cup fruit juice or regular pop, 1 fruit roll up, 5-6 lifesavers or glucose gel)  If blood sugar is <50 give 2 sugar source treatments.  Wait 15-20 minutes. Re-test & re-treat until blood sugar is above target range. If more than 1 hour until meal or snack, give 3 graham  crackers, 6 saltines, or 1 cup of milk.  If low before meal or snack: Treat to get back in range before allowing student to go to meal. If indicated, bolus for food eaten at meal;  Do not give corrective dose after treatment of a low blood sugar.  Notify parent/guardian of low blood sugar & treatment given.  Comments/Special Instructions:  Treatment for **unconscious/seizing** student:  Administer Glucagon Injection  1 vial  ½ Vial  Contact 911.  Test blood sugar every 10 minutes.  If student arouses prior to EMS arriving give sips of regular soda and crackers.  Do not give liquids to drink while unresponsive.  Notify parent/guardian.  **Treatment of High Blood Sugar (Hyperglycemia):** Hyperglycemia is a blood sugar great than \_\_\_\_\_\_\_\_\_\_.  If blood sugar is over \_\_\_\_\_\_\_\_ check urine for ketones.  Allow unrestricted bathroom privileges.  Encourage extra sugar free liquids, i.e., water, diet drinks   * Negative Ketones: 8-12oz every ½ to 1 hour * Trace or Small Ketones: 8-12oz every ½ to 1 hour & inform parent/guardian * Moderate or Large Ketones: Notify parent/guardian and/or Diabetes Provider (additional insulin may be required)   Student should NOT participate in exercise-related activities.  Call parent/guardian and/or Diabetes Provider if vomiting occurs.  Comments/Special Instructions: |

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

**DIABETES PROVIDER SIGNATURE PLEASE PRINT PROVIDER NAME DATE**

I give permission for the school nurse and any pertinent staff caring for my child to follow this plan, administer medication and care for my child, contact the diabetes care provider if necessary and for this form to be faxed/emailed to my child’s school or be shared with school staff per FERPA guidelines. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices, as well as snacks & treatment for the classroom.

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

**PARENT/GUARDIAN SIGNATURE DATE**

*CC: Tina Brinkman, RN/Nikki Al Khatib, RN*

**SEIZURE ACTION PLAN – residential & non-residential students:**

**SEIZURE ACTION PLAN IS REQUIRED ONLY IF YOUR CHILD HAS A CURRENT DIAGNOSIS OF SEIZURES**  *Page 10 – 2017-2018*

**TO BE COMPLETED BY PARENT/GUARDIAN:**

Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade Level: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: (Home) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Work) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Cell) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Seizure Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Office Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Office Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office Email (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School Nurse Email: [cbrinkma@bsu.edu](mailto:cbrinkma@bsu.edu) (Tina Brinkman) School Nurse Phone: (765) 285-7360 School Nurse Fax: (765) 285-0063

|  |  |
| --- | --- |
| **TO BE COMPLETED BY**  **SEIZURE CARE PROVIDER:** | Seizure triggers or warning signs:  Student’s response after a seizure: |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Seizure Information:** | |  | |  | | |  |
| **Seizure Type** | | **Length** | | **Frequency** | | | **Description** |
|  | |  | |  | | |  |
|  | |  | |  | | |  |
|  | |  | |  | | |  |
| **Seizure Care & Plan of Action:** | | | |  | | | |
| **Basic First Aid: Care & Comfort:**  Please describe basic first aid procedures (if different from instructions to the right):  Does student need to leave the classroom after a seizure?  Yes  No  If yes, describe process for returning student to the classroom:  **Emergency Response:**  Please describe emergency procedures (if different from instructions to the right):  A “seizure emergency” for this student is defined as: | | | | | **Basic Seizure First Aid**   * Stay calm & track time (start & end time) * Keep child safe * Do not restrain * Do not put anything in mouth * Stay with child until fully conscious * Inform school nurse * Notify parent/guardian   **For Tonic-Clonic Seizure (convulsive)**   * Protect head * Keep airway open/watch breathing * Turn child on side | | |
| **A seizure is generally considered an emergency when:** | | | | | **Seizure Emergency Protocol** | | |
| * Convulsive (tonic-clonic) seizure lasts longer than 5 minutes * Student has repeated seizures without regaining consciousness * Student is injured or has diabetes * Student has a first-time seizure * Student has breathing difficulties * Student has a seizure in water | | | | | * Call 911 * Administer emergency medications as indicated below * Contact School Nurse * Notify parent/guardian * Notify Seizure Provider * Other: | | |
| **Treatment Protocol (include daily & emergency medications:** | | | | | | | |
| **Emergency**  **Med ✓** | **Medication Name** | | **Dosage & Time of Day Given** | | | **Common Side Effects & Special Instructions** | |
|  |  | |  | | |  | |
|  |  | |  | | |  | |
|  |  | |  | | |  | |

Does student have a **Vagus Nerve Stimulator**?  Yes  No If YES, describe magnet use:

|  |
| --- |
| **Special Considerations & Precautions (regarding school activities, sports, trips, etc.):** |
| Describe any special considerations or precautions: |

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

**SEIZURE PROVIDER SIGNATURE PLEASE PRINT PROVIDER NAME DATE**

I give permission for the school nurse and any pertinent staff caring for my child to follow this plan, administer medication and care for my child, contact the seizure provider if necessary and for this form to be faxed/emailed to my child’s school or be shared with school staff per FERPA guidelines. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices.

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

**PARENT/GUARDIAN SIGNATURE DATE**

*CC: Tina Brinkman, RN/Nikki Al Khatib, RN*

**SEVERE ALLERGY & ANAPHYLAXIS ACTION PLAN – residential & non-residential students:**

**ALLERGY/ANAPHYLAXIS ACTION PLAN IS REQUIRED ONLY IF YOUR CHILD HAS A CURRENT DIAGNOSIS OF SEVERE ALLERGIES**  *Page 11 – 2017-2018*

**TO BE COMPLETED BY PARENT/GUARDIAN:**

Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade Level: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: (Home) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Work) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Cell) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergy Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Office Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Office Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office Email (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School Nurse Email: [cbrinkma@bsu.edu](mailto:cbrinkma@bsu.edu) (Tina Brinkman) School Nurse Phone: (765) 285-7360 School Nurse Fax: (765) 285-0063

|  |  |
| --- | --- |
| **TO BE COMPLETED BY**  **ALLERGY CARE PROVIDER:** | Please list all allergies here::  Student is extremely reactive to the following: |

|  |  |
| --- | --- |
| **Plan of Action:** |  |
| **Plan of Action for “MILD” symptoms:**  1.  Yes  No Inject Epinephrine immediately for ANY symptoms if  likely exposed to allergen?   * Nose (itchy/runny nose, sneezing) * Mouth (itchy mouth) * Skin (a few hives, mild itch) * Gut (mild nausea/discomfort)   2. Give antihistamines, if ordered by provider (see list of medications).  3. Stay with student.  4. Watch student closely for changes.  5. If symptoms worsen, INJECT Epinephrine if ordered by provider (see  list of medications).  Additional Comments/Instructions: | **Plan of Action for “SEVERE” symptoms:**  1. .  Yes  No Inject Epinephrine immediately if was definitely  exposed to the allergen, even if there are no symptoms?   * Lung (shortness of breath, wheezing, repetitive cough) * Heart (pale, blue, faint, weak pulse, dizziness) * Throat (tight, hoarse, trouble breathing/swallowing) * Mouth (significant swelling of tongue and/or lips) * Skin (many hives over body, widespread redness) * Gut (repetitive vomiting or severe diarrhea) * Other (feeling something bad is about to happen, anxiety, confusion) * Or a combination of mild or severe symptoms from different body areas   2. INJECT Epinephrine immediately.  3. Call 911. Request ambulance with Epinephrine.  4. Consider giving additional medications following or with the  Epinephrine (see list of medications).   * Antihistamine * Inhaler if asthmatic (bronchodilator)   5. Lay student flat & raise legs. If breathing is difficult or student is  vomiting, let him/her sit up or lie on their side.  6. If symptoms do not improve, or symptoms return, more doses of  Epinephrine can be given about 5 minutes or more after the  last dose.  7. Stay with student.  8. Transport to ER via ambulance even if symptoms resolve. Student  should remain in ER for approximately 4+ hours in case  symptoms return.  9. Notify parent/guardian. |

|  |  |  |  |
| --- | --- | --- | --- |
| **Medications:** | | | |
|  | **Medication Name** | **Dosage** | **Special Instructions/Directions** |
| Epinephrine | .  Epipen Auto-Injector  Auvi-Q   Adrenaclick | .  0.15mg IM  0.3mg IM |  |
| Antihistamine | .  Claritin  Zyrtec  Allegra .   Benadryl  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| Inhaler | 1.  2. |  |  |
| Other |  |  |  |

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

**ALLERGY PROVIDER SIGNATURE PLEASE PRINT PROVIDER NAME DATE**

I give permission for the school nurse and any pertinent staff caring for my child to follow this plan, administer medication and care for my child, contact the allergy provider if necessary and for this form to be faxed/emailed to my child’s school or be shared with school staff per FERPA guidelines. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices.

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

**PARENT/GUARDIAN SIGNATURE DATE**

*CC: Tina Brinkman, RN/Nikki Al Khatib, RN*

**Religious Exemption to Vaccination (s) – residential & non-residential students:**

**THIS SECTION IS REQUIRED ONLY IF YOU CHILD HAS A RELIGIOUS EXEMPTION TO A VACCINATION**

*Page 12 – 2017-2018*

Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Due to our **religious beliefs,** the following vaccines are incomplete or missing for our child (please circle all vaccines that apply):

Tetanus/Diphtheria/Pertussis Polio Measles/Mumps/Rubella

Hepatitis B Meningitis Chicken Pox/Varicella

* I, the parent/guardian, understand that my child may be excluded from school in the event of an outbreak of a vaccine preventable disease for which he/she is not vaccinated.
* I, the parent/guardian, understand that exclusion includes the dorm, school, and after=school activities, such as sporting events, dances, and graduation.
* I, the parent/guardian, understand that my child may be required to stay home for multiple weeks during an outbreak of a vaccine preventable disease for which he/she is not vaccinated.

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

**PARENT/GUARDIAN SIGNATURE PLEASE PRINT NAME DATE**

**Medical Exemption to Vaccination (s) – residential & non-residential students:**

**THIS SECTION IS REQUIRED ONLY IF YOU CHILD HAS A MEDICAL EXEMPTION TO A VACCINATION**

Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TO BE COMPLETED BY A PHYSICAN:**

* *All columns below must be completed in order to exempt a child from school immunization requirements*

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of**  **Exempted**  **Vaccine** | **Reason**  **For**  **Exemption** | **Permanent or Temporary**  **Exemption**  **(*please circle)*** | **Date the Temporary**  **Exemption Ends**  ***(if applicable)*** |
|  |  | Permanent or Temporary |  |
|  |  | Permanent or Temporary |  |
|  |  | Permanent or Temporary |  |
|  |  | Permanent or Temporary |  |
|  |  | Permanent or Temporary |  |
|  |  | Permanent or Temporary |  |

*Please place any additional information/comments here:*

Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office Email (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*CC: Tina Brinkman, RN/Nikki Al Khatib, RN*

**

Page 1 – FYI

**Heads Up…Concussion in High School Sports/Activities**

***A Fact Sheet for Students***

|  |  |
| --- | --- |
| **What is a Concussion?** | **What are the symptoms of a Concussion?** |
| A concussion is a brain injury that: | * Headache or “pressure” in head |
| * Is caused by a bump, blow, or jolt to the head or body | * Balance problems or dizziness |
| * Can change the way your brain normally works | * Bothered by light or noise |
| * Can occur during practices or games in any sport or recreational activity | * Feeling sluggish, hazy, foggy, or groggy |
| * Can happen even if you haven’t been knocked out | * Nausea or vomiting |
| * Can be serious even if you’ve just been “dinged” or “had your bell rung” | * Double or blurry vision |
|  | * Difficulty paying attention |
|  | * Memory problems |
|  | * Confusion |

*All concussions are serious. A concussion can affect your ability to do schoolwork and other activities (such as playing video games, working on a computer, studying, driving, or exercising). Most people with a concussion get better, but it is important to give your brain time to heal.*

*You can’t see a concussion, but you might notice* ***one or more*** *of the symptoms listed above or that you “don’t feel right” soon after, a few days after, or even weeks after the injury.*

**What should I do if I think I have a concussion?**

* **Tell your coach, student life counselor and your parent/guardian.** Never ignore a bump or blow to the head even if you feel fine. Also, tell your coach, student life counselor right away if you think you or one of your friends/teammates might have a concussion.
* **Get a medical check-up.** A doctor or other health care professional can tell if you have a concussion and when it is OK to return to activity/sport/intramural.
* **Give yourself time to get better.** If you have a concussion, your brain needs time to heal. While your brain in still healing, you are much more likely to have another concussion. Repeat concussions can increase the time it takes for you to recover and may cause more damage to your brain. It is important to rest and not return to activity/sport/intramural until you get the OK from your health care professional that you are symptom free.

|  |  |
| --- | --- |
| **How can I prevent a concussion?** | **If you think you have a concussion:** |
| 1. Use the proper sports equipment, including personal protective equipment. In order for the equipment to protect you, it must be: | Don’t hide it  Report it |
| * The right equipment for the game, position, or activity | Take time to recover |
| * Worn correctly and the correct size and fit |  |
| * Used every time you play or practice |  |
| 1. Follow your coach’s/slc’s rules for safety and the rules of the sport |  |
| 1. Practice good sportsmanship |  |

**Sudden Cardiac Arrest**

**A Fact Sheet for Students**

**Facts:** Sudden cardiac arrest can occur even in athletes who are in peak shape. Approximately 500 deaths are attributed to sudden cardiac arrest in athletes each year in the United States. Sudden cardiac arrest can affect all levels of athletes, in all sports, and in all age levels. The majority of cardiac arrests are due to congenital (inherited) heart defects. However, sudden cardiac arrest can occur after a person experiences an illness which has caused an inflammation to the heart or after a direct blow to the chest. Once cardiac arrest occurs, there is very little time to save the athlete, so identifying those at risk before the arrest occurs is a key factor in prevention.

**Warning Signs:** There may not be any noticeable symptoms before a person experiences loss of consciousness and a full cardiac arrest (no pulse and no breathing). ***Warning signs* can include a complaint of:**

|  |  |
| --- | --- |
| * Chest discomfort | * Unusual shortness of breath |
| * Racing or irregular heartbeat | * Fainting or passing out |

**Emergency Signs:** If a person experiences any of the following ***Emergency*** signs, call **EMS (911)** immediately:

|  |  |
| --- | --- |
| * If an athlete collapse suddenly during competition | * If a blow to the chest from a ball, puck or another player precedes an |
| * If an athlete does not look or feel right and you are just not sure | athlete’s complaints of any of the warning signs of sudden cardiac arrest |

**How can I help prevent a sudden cardiac arrest?** Daily physical activity, proper nutrition, and adequate sleep are all important aspects of life-long health. Additionally, you can assist by:

* Knowing if you have a family history of sudden cardiac arrest (onset of heart disease in a family member before the age of 50 or a sudden, unexplained death at an early age.
* Telling your health care provider during your pre-season physical about any usual symptoms of chest discomfort, shortness of breath, racing or irregular heartbeat, or feeling faint, especially if you feel these symptoms with physical activity.
* Taking only prescription drugs that are prescribed to you by your health care provider.
* Being aware that the inappropriate us of prescription medications or energy drinks can increase your risk.
* Being honest and reporting symptoms of chest discomfort, unusual shortness of breath, racing or irregular heartbeat, or feeling faint.

**What should I do if I think I am developing warning signs that may lead to sudden cardiac arrest?**

* Tell an adult – your parent/guardian, your coach/slc, your athletic trainer or your school nurse.
* Get checked out by your health care provider.
* Take care of your heart.
* Remember that the most dangerous thing you can do is to do nothing.

This page was last reviewed March 16, 2017



Page 2– FYI

**Heads Up…Concussion in High School Sports/Activities**

***A Fact Sheet for Parents/Guardians***

**What is a concussion?** A concussion is a brain injury. Concussions are caused by a bump, blow, or jolt to the head or body. Even a “ding,” “getting your bell rung,” or what seems to be a mild bump or blow to the head can be serious.

**What are the signs and symptoms?** You can’t see a concussion. Signs and symptoms of concussion can show up right after the injury, or may not appear or be noticed until days after the injury. If you teen reports **one or more** symptoms of concussion listed below, or if you notice the symptoms yourself, keep your teen out of play and seek medical attention right away.

|  |  |
| --- | --- |
| **Signs Observed by Parent/Guardian:** | **Symptoms Reported by Student:** |
| Appears dazed or stunned | Headache or “pressure” in head |
| Is confused about assignment or position | Nausea or vomiting |
| Forgets an instruction | Balance problems or dizziness |
| Is unsure of game, score, or opponent | Double or blurry vision |
| Moves clumsily | Sensitivity to light or noise |
| Answers questions slowly | Feeling sluggish, hazy, foggy, or groggy |
| Loses consciousness (even briefly) | Concentration or memory problems |
| Shows mood, behavior, or personality changes | Confusion |
| Can’t recall events *prior* to hit or fall | Just not “feeling right” or is “feeling down” |
| Can’t recall events *after* hit or fall |  |

**How can you help your teen prevent a concussion?** Every sport is different, but there are steps your teens can take to protect themselves from concussions or other injuries.

* Make sure they wear the right protective equipment for their activity. If should fit properly, be well maintained, and be worn consistently and correctly.
* Ensure that they follow their coach/slc rules for safety and the rules of the sport.
* Encourage them to practice good sportsmanship at all times.

**What should you do if you think your teen has a concussion?**

1. **Keep your teen out of play.** If your teen has a concussion, her/his brain needs time to heal. Don’t let your teen return to play the day of the injury and until a health care professional, experienced in evaluating for concussion, says your teen is symptom-free and it’s OK to return to play. A repeat concussion that occurs before the brain recovers from the first – usually within a short period of time (hours, days, or weeks) – can slow recovery or increase the likelihood of having long-term problems. In rare cases, repeat concussions can result in edema (brain swelling), permanent brain damage, and even death.
2. **Seek medical attention right away.** A health care professional experienced in evaluating for concussion will be able to decide how serious the concussion is and when it is safe for your teen to return to sports.
3. **Teach your teen that it’s not smart to play with a concussion.** Rest is key after a concussion. Sometimes athletes wrongly believe that it shows strength and courage to play injured. Discourage others from pressuring injured athletes to play. Don’t let the teen convince you that s/he’s “just fine.”
4. **Tell all of your teen’s coaches, student life counselor and the school nurse about ANY concussion.** Coaches, school nurses, and other school staff should know if your teen has ever had a concussion. Your teen may need to limit activities while s/he is recovering from a concussion. Things such as studying, driving, working on a computer, playing video games, or exercising may cause concussion symptoms to reappear or get worse. Talk to your health care professional, as well as your teen’s coach, slc, school nurse, and teachers. If needed, they can help adjust your teen’s school activities during her/his recovery.

**If you think your teen has a concussion:** 1) Don’t assess it yourself…2) Take him/her out of play…3) Seek the advice of a health care professional.

**Sudden Cardiac Arrest**

**A Fact Sheet for Parents/Guardians**

**Facts:** Sudden cardiac arrest is a rare, but tragic event that claims the lives of approximately 500 athletes each year in the United States. Sudden cardiac arrest can affect all levels of athletes, in all sports, and in all age levels. The majority of cardiac arrests are due to congenital (inherited) heart defects. However, sudden cardiac arrest can also occur after a person experiences an illness which has caused an inflammation to the heart or after a direct blow to the chest.

**Warning Signs:** There may not be any noticeable symptoms before a person experiences loss of consciousness and a full cardiac arrest (no pulse and no breathing).

***Warning signs*** can include a complaint of: 1) chest discomfort…2) unusual shortness of breath…3) racing or irregular heartbeat…4) fainting or passing out.

**Emergency Signs:** If a person experiences any of the following signs, call EMS (911) immediately:

* If an athlete collapses suddenly during competition.
* If a blow to the chest from a ball, puck or another player precedes an athlete’s complaints of any of the warning signs of sudden cardiac arrest.
* If an athlete does not look or feel right and you are just not sure.

**How can I help my child prevent a sudden cardiac arrest?** Daily physical activity, proper nutrition, and adequate sleep are all important aspects of life-long health. Additionally, parents can assist student athletes prevent a sudden cardiac arrest by:

* Ensuring your child knows about any family history of sudden cardiac arrest (onset of heart disease in a family member before the age of 50 or a sudden, unexplained death at an early age).
* Ensuring your child has a thorough pre-season screening exam prior to participation in an organized athletic activity.
* Asking if your school and the site of competition has an automatic defibrillator (AED) that is close by and properly maintained.
* Learning CPR yourself.
* Ensuring your child is not using any non-prescribed stimulants or performance enhancing drugs.
* Being aware that the inappropriate us of prescription medications or energy drinks can increase risk.
* Encouraging your child to be honest and report symptoms of chest discomfort, unusual shortness of breath, racing or irregular heartbeat, or feeling faint.

**What should I do if I think my child has warning signs that may lead to sudden cardiac arrest?**

* Tell your child’s coach/slc about any previous events or family history.
* Keep your child out of play
* Seek medical attention right away

This page was last reviewed March 16, 2017



Page 3 – FYI

**Quick Facts**

**What is Meningococcal Disease?**

*Neisseria meningitidis* bacteria are found in the nose and throat of 10 – 15% of healthy adults. Rarely, the bacteria can enter areas of the body where bacteria are normally not found, such as the blood or fluid surrounding the brain and spinal cord (meningitis) and cause a severe, life-threatening infection (“invasive disease”) known as meningococcal disease.

**How is Meningococcal Disease spread?**

The disease is not spread by casual contact or by attending the same work or school setting. *Neisseria meningitidis* bacteria are spread from person to person *only through* direct contact with an infected person’s nose or throat secretions, including saliva, 1 week before the onset of symptoms. Some common ways the bacteria can be spread from an infected person are:

· Living the same household

· Kissing on the lips

· Sharing drinks from the same container (glasses, cups, water bottles)

· Sharing eating with utensils (forks and spoons)

· Sharing a toothbrush, cigarettes or lipstick

Preventive antibiotic therapy is recommended for individuals identified to be close contacts of someone who is sick with the disease.

**Who is at risk for Meningococcal Disease?**

Young infants and students attending high school or college and military recruits are more likely to get the disease. Individuals with a weakened immune system are also at higher risk for the disease as well as those who live in crowded dwellings or have household exposure to cigarette smoke.

**What are the signs of being sick with Meningococcal Disease?**

Symptoms of meningococcal disease include:

· Fever (abrupt onset)

· Severe headache

· Stiff neck

· Drowsiness or confusion

· Skin rash that appears as bruising or bleeding under the skin

· Nausea and vomiting

· Sensitivity to light

In babies, the symptoms are more difficult to identify but may include:

· Fever

· Fretfulness or irritability

· Poor appetite

· Difficulty in waking the baby

**How is meningococcal disease diagnosed?**

If you have any of the above symptoms, it is important to seek medical attention immediately. An infected person may become sick within a few hours of developing symptoms. Your health care provider may collect blood or perform a spinal tap to obtain spinal fluid to see if meningococcal bacteria are present.

**How can Meningococcal Disease be treated?**

Meningococcal disease is treated with several different types of antibiotics, and early treatment may reduce the risk of complications or death from the disease. A 24-hour course of antibiotic therapy reduces a person’s likelihood of spreading the bacteria. Supportive care in an intensive care unit may be necessary for those with severe infection and surgery may be needed to remove damaged tissue and stop the spread of infection.

**How is Meningococcal Disease prevented?**

Meningococcal disease can be prevented by good hygiene. Cover the nose and mouth when sneezing or coughing, throw away used tissues, and wash hands often. Do not share eating or drinking utensils with anyone.

**Is there a vaccine that can prevent this disease?**

Yes, there is a vaccine for Meningitis Serogroups A, C, W, and Y. One (1) dose of a meningococcal conjugate vaccine (MCV4) is required for high school juniors. A booster dose (or 2nd dose) of MCV4 is required for high school seniors starting with the 2014-2015 school year.

Yes, there is a vaccine for Meningitis Serogroup B. This vaccine is currently recommended but no required. It is likely that it will become law starting with the senior year of the Class of 2019. Meningococcal vaccine is also recommended for other people at increased risk for meningococcal disease:

· College freshmen living in dormitories

· U. S. military recruits

· Travelers to countries where meningococcal disease is common, such as parts of Africa

· Anyone with a damaged spleen, or whose spleen has been removed

· Persons with certain medical conditions that affect their immune system (check with your physician)

· Microbiologists who are routinely exposed to meningococcal bacteria

For information on the availability of meningococcal vaccine contact your family physician or local health department. Revaccination after 5 years may be indicated for certain at-risk individuals.

All information presented is intended for public use. For more information, please refer to the Centers for Diseases and Control Prevention (CDC)

meningitis website at: http://www.cdc.gov/meningitis/about/index.html

This page was last reviewed March 24, 2017



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**OVERVIEW OF THE INDIANA ACADEMY PRESCRIPTION MEDICATION POLICY**

1. In order for a student to be allowed to keep their prescription medication in their dorm room, consent for self-administration must be obtained by both the parent/guardian and healthcare provider. These consents must be on file prior to move-in day and is located in the health packet.
2. All prescription medication must be turned in on move-in day. Please pack it separately as the nursing staff will request it when you are checking in.
3. Most, but not all, prescription medication will be permitted in student dorm rooms. Prescription medication, such as controlled substances (schedules 1 – 5) will not be permitted in student dorm rooms (even if consent for self administration is given).
   * Prescription medication must be turned in on move-in day.
   * A 14-day supply (of most medication) will be returned to the student via his/her mailbox (if both consents are on file)
   * When a student’s 14-day supply is low or depleted, the student should return his/her medication bottle to the nurse’s office or mailbox. The mailbox is located at the Academy front desk.
   * The medication will be replenished and returned to the students’ mailbox. Students will be notified, in person or in writing, when a pharmacy refill is needed.
   * Refills on current medication, new medications or medications brought from home that have not already been logged in by the nurse must be turned in promptly to the nurse’s office or mailbox. The nurse’s must log in each and every prescription medication, as well as each and every refill. Once they are logged in, the nurses will return the appropriate amount of medication to the student for self administration. Controlled medication will be logged in and placed on the medication cart.
   * Please contact the nursing office as soon as possible if a prescription medication has been changed or discontinued.
   * **It is against the law to have a prescription medication in your possession that is not prescribed to you. All prescription medication must be logged in with the nurse’s office and properly labeled with the student name, medication name, dosage, frequency & any specific instructions. Students found in violation of this policy will face disciplinary action (grounding, suspension, expulsion, etc…).**
4. The ultimate decision for self-administration of **ANY** prescription medication is at the discretion of the Coordinator of Healthcare Services. Self-administration of any prescription medication is a privilege. This privilege can be revoked at any time should the student demonstrate a total disregard for our medication policy or a lack of compliance in taking their medication.
5. A ***Medication Administration Log*** will be kept on prescription medication.
6. Student compliance will be monitored to the best of our ability. The parent/guardian will be notified periodically of compliance/non-compliance.
7. Any changes in medication (including discontinuation) must be reported to the nurse’s office ASAP by the parent/guardian.
8. If you are not restricted in where you can fill prescriptions, it might be easier for you to obtain written prescriptions from your physician for medications your student is taking. Our nursing staff will fill it when it is needed, as well as obtain the refills when needed. The amount/co-pay due will be billed to the students’ Bursar Account and Ball State University will send you a bill for it. In most cases, this is most convenient for the student and parent….sometimes students are not home when refills are needed and the parent would not have to mail the medication here. It is a win-win situation for most students and parents as long as you do not have to use specific pharmacies or mail in companies. We can only have the amount billed home if we use the Ball State Health Center Pharmacy (part of IU Health). If you obtain written prescriptions from your physician please turn them in on move-in day.
9. Please contact the nursing office if you have any questions at (765) 285-7360.
10. NECP students will only need to log in medication if he/she needs prescription medication during the school day. Otherwise, he/she can take their prescription medication before or after the school day.

**Controlled Substance Schedules:**

Schedule 1: These medications are not accepted for medical use and therefore are not permitted in our building.

Schedule 2: Examples include narcotics, amphetamines and some barbiturates.

Schedule 3: Examples include non barbiturate sedatives, non amphetamine stimulants, anabolic steroids and limited amounts of certain

narcotics.

Schedule 4: Examples include some sedatives, anxiolytics and non-narcotic analgesics.

Schedule 5: Examples include a small number of narcotics, such as codeine used in antitussives (cough syrup) or antidiarrheals.

**IMMUNIZATION REQUIREMENTS & RECOMMENDATIONS**

***An up-to-date & complete immunization record is required no later than move-in day***

|  |  |  |
| --- | --- | --- |
| **Vaccine** | **# of Doses Required** | **Comments** |
| Tetanus (Dtap/Dtp/Dt/Td) | 5 | 4 doses are acceptable ONLY if the 4th dose was administered on or after the 4th birthday, otherwise the student must have 5 doses. |
| Tdap (acellular pertussis) | 1 | All students in grades 6-12 must have 1 documented Tdap Vaccine. |
| Polio | 4 | 3 doses are acceptable ONLY if the 3rd dose was given on or after the 4th birthday **AND** at least 6 months after the previous dose **AND** with only one type of vaccine used (i.e. all OPV or all IPV). |
| Measles/Mumps/Rubella (MMR) | 2 | 2 Measles, 2 Mumps & 1 Rubella Vaccines are acceptable in place of 2 MMR Vaccines. |
| Hepatitis B | 3 | All students must have 3 documented Hepatitis B Vaccines. |
| Varicella (chicken pox) | 2 | 2 doses are required if the student HAS NOT had the chicken pox disease. If the student has had the disease then proof of the disease is required (month & year of the disease). |
| Meningitis (MCV4) | 1 (junior year)  2 (senior year) | 1 dose is required for your junior year. A booster dose (or 2nd dose) is required for your senior year. |
| Serogroup B Meningococcal (Men B) | See Comments | 2 doses are recommended for the 2017-2018 school year. At this time, it is proposed, but likely will become law that 2 doses will be required at the beginning of the senior year for the class of 2019. |
| Hepatitis A | See Comments | 2 doses are recommended for the 2017-2018 school year. At this time, it is proposed, but likely will become law that 2 doses will be required at the beginning of the senior year for the class of 2019. |

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