Dear Parent/Guardian:

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 requirements for your student along with important due dates for each item:

<table>
<thead>
<tr>
<th>Health Requirements</th>
<th>DUE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Required:</strong> Pages 1 thru 5 of the health packet are to be completed by the parent/guardian.</td>
<td></td>
</tr>
<tr>
<td>• Student will need to complete &amp; sign the top of page 5.</td>
<td>Junior: Orientation</td>
</tr>
<tr>
<td>• Parent/Guardian will need to complete &amp; sign the bottom of page 5.</td>
<td>Senior: July 20, 2018</td>
</tr>
<tr>
<td><strong>Required:</strong> Please provide a copy of your child’s Medical &amp; Prescription Card(s), both front &amp; back.</td>
<td></td>
</tr>
<tr>
<td>• We require new copies annually.</td>
<td>Junior: July 20, 2018</td>
</tr>
<tr>
<td>• If you have a separate card for prescriptions, please include a front &amp; back copy of it too.</td>
<td>Senior: July 20, 2018</td>
</tr>
<tr>
<td><strong>Required:</strong> Please supply a copy of your child’s Immunization Record.</td>
<td></td>
</tr>
<tr>
<td>• <strong>Juniors:</strong> required to submit a complete &amp; up-to-date copy of their immunization record. Please see FYI Form B Page 4 for a complete list of the required immunizations.</td>
<td></td>
</tr>
<tr>
<td>• <strong>Seniors:</strong> required to have 2 Meningitis Vaccines (MCV4) &amp; 2 Hepatitis A Vaccines. If you have not already completed these 2 vaccine series, please obtain them &amp; provide a copy of the updated Immunization Record. Please see FYI Form B Page 4 for a complete list of the required immunizations.</td>
<td>Junior: July 20, 2018</td>
</tr>
<tr>
<td><strong>If Applicable:</strong> Page 6 for prescription medication.</td>
<td></td>
</tr>
<tr>
<td>• This page is ONLY required if your child has prescription medication (such as: oral meds, birth control pills/patches, inhalers, insulin, nasal sprays, topical meds).</td>
<td></td>
</tr>
<tr>
<td>• Consent for self-administration of non-controlled prescription medication is required by both the parent/guardian &amp; prescriber.</td>
<td></td>
</tr>
<tr>
<td>• Your child will NOT be permitted to self-administer his/her medication until both consents are on file. As well, there could be a delay in your child self-administering his/her medication if the appropriate consents are not on file by July 20, 2018.</td>
<td></td>
</tr>
<tr>
<td><strong>If Applicable:</strong> Action Plans (pages 7 – 10) – to be completed by health provider and signed by both the provider &amp; parent/guardian ONLY if your child has a diagnosis of: Asthma, Diabetes, Seizure Disorder/Epilepsy or Severe/Life Threatening Allergies.</td>
<td></td>
</tr>
<tr>
<td><strong>If Applicable:</strong> Page 11 for Religious Exemption to vaccinations.</td>
<td></td>
</tr>
<tr>
<td>• A written statement from the parent/guardian is required if your child has a religious exemption to any vaccine.</td>
<td></td>
</tr>
<tr>
<td>• You can use the top of page 11 or provide a statement of your own.</td>
<td></td>
</tr>
<tr>
<td><strong>If Applicable:</strong> Page 12 for Medical Exemption to vaccinations.</td>
<td></td>
</tr>
<tr>
<td>• A written statement from your physician is required if your child has a medical exemption to any vaccine.</td>
<td></td>
</tr>
<tr>
<td>• The physician may use the bottom of page 11 or provide a statement of his/her own.</td>
<td></td>
</tr>
</tbody>
</table>

To avoid long lines on move in day, please make sure the above items are complete and submitted by the listed due date. Please review the Immunization Requirements/Recommendations on FYI Form B Page 4 as the Indiana Department of Health has made changes for the 2018-2019 school year. Please do not hesitate to let us know if you have any questions. Thank you!!

Sincerely,

Tina Brinkman, RN  
Coordinator of Healthcare Services  
cbrinkma@bsu.edu  
(765) 285-7360  
(765) 285-0063 fax  
Indiana Academy for Science, Mathematics, & Humanities  
Wagoner Complex, Ball State University  
Muncie, IN 47306

Nikki Al Khatib, RN  
School Nurse  
nalkhatib@bsu.edu  
(765) 285-7360  
(765) 285-0063 fax  
Indiana Academy for Science, Mathematics, & Humanities  
Wagoner Complex, Ball State University  
Muncie, IN 47306
Student’s Legal Name: ____________________________________________________ Goes By: ________________________________

STUDENT INFORMATION: Residential & Non-Residential Students

Grade Level:  
- _____ 11th _____ 11th NECP  
- _____ 12th _____ 12th NECP  
- _____ 11th International  
- _____ 12th International  
- _____ Other (specify) ____________________

Gender: _____ Male     _____ Female  
Student Cell Phone #: (______) _______ - ________

DELEGATION OF AUTHORITY TO CONSENT TO HEALTHCARE – Residential & Non-Residential Students
(Consent for healthcare services, as necessary, in the absence of the parent/guardian)

Student/Minor Children Information:

<table>
<thead>
<tr>
<th>Student Name(s)</th>
<th>Date of Birth</th>
<th>Allergies</th>
<th>Special Medical Problems</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Minor Children Name(s)</th>
<th>Date of Birth</th>
<th>Allergies</th>
<th>Special Medical Problems</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I, the parent/guardian, of the above named children, hereby delegate authority to consent to 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, 2018 to July 1, 2019

Parent/Guardian Signature(s):

Parent Name (1): ____________________________________________________ (2): ____________________________________________________

Address:  
_________________________________________________________________________________

City/State/Zip:  
_________________________________________________________________________________

Signature (s):  
_________________________________________________________________________________

Date:  
_________________________________________________________________________________

Witness Signature:

Witness Signature: ____________________________________________________

Address:  
_________________________________________________________________________________

City/State/Zip:  
_________________________________________________________________________________

The parent/guardian is responsible for all student medical expenses incurred while at the Indiana Academy for Science, Mathematics, and Humanities

CC: Tina Brinkman, RN/Nikki Al Khatib, RN
<table>
<thead>
<tr>
<th>HEALTH INFORMATION: Residential &amp; Non-Residential Students</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Please check “yes or no” to each &amp; comment on all “yes” responses)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DO YOU HAVE?</th>
<th>YES</th>
<th>NO</th>
<th>COMMENT/ANSWER (if applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety</td>
<td></td>
<td></td>
<td>Medicine: _____ Yes _____ No</td>
</tr>
<tr>
<td>Arthritis</td>
<td></td>
<td></td>
<td>Type:</td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
<td>Inhaler: _____ Yes _____ No</td>
</tr>
<tr>
<td>Crohn’s Disease</td>
<td></td>
<td></td>
<td>Nebulizer: _____ Yes _____ No</td>
</tr>
<tr>
<td>Depression</td>
<td></td>
<td></td>
<td>Medicine: _____ Yes _____ No</td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
<td>Type:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Date of Diagnosis:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Insulin Pump: _____ Yes _____ No</td>
</tr>
<tr>
<td>Eating Disorder</td>
<td></td>
<td></td>
<td>Type/Specify:</td>
</tr>
<tr>
<td>Epilepsy/Seizures</td>
<td></td>
<td></td>
<td>Medicine: _____ Yes _____ No</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Date of Diagnosis:</td>
</tr>
<tr>
<td>Hearing Impairment</td>
<td></td>
<td></td>
<td>Left _____ Right _____ Both</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Hearing Aids: _____ Yes _____ No</td>
</tr>
<tr>
<td>High or Low Blood Pressure</td>
<td></td>
<td></td>
<td>Medicine: _____ Yes _____ No</td>
</tr>
<tr>
<td>Insomnia</td>
<td></td>
<td></td>
<td>_____ High _____ Low</td>
</tr>
<tr>
<td>Irritable Bowel Syndrome (IBS)</td>
<td></td>
<td></td>
<td>Medicine: _____ Yes _____ No</td>
</tr>
<tr>
<td>Menstrual Cramps</td>
<td></td>
<td></td>
<td>Describe:</td>
</tr>
<tr>
<td>Mental Illness</td>
<td></td>
<td></td>
<td>Season (s):</td>
</tr>
<tr>
<td>Seasonal Allergies</td>
<td></td>
<td></td>
<td>Type:</td>
</tr>
<tr>
<td>Skin Disorder</td>
<td></td>
<td></td>
<td>Medicine: _____ Yes _____ No</td>
</tr>
<tr>
<td>Thyroid Disorder</td>
<td></td>
<td></td>
<td>Type:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Medicine: _____ Yes _____ No</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td></td>
<td></td>
<td>Medicine: _____ Yes _____ No</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Date of Onset:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Date of last chest x-ray:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HAVE YOU?</th>
<th>YES</th>
<th>NO</th>
<th>COMMENT/ANSWER (if applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Had Chicken Pox</td>
<td></td>
<td></td>
<td>Date or Age of Disease:</td>
</tr>
<tr>
<td>Attempted Suicide</td>
<td></td>
<td></td>
<td>Date:</td>
</tr>
<tr>
<td>Been Pregnant</td>
<td></td>
<td></td>
<td>Describe:</td>
</tr>
<tr>
<td>Had Broken Bones</td>
<td></td>
<td></td>
<td>Date:</td>
</tr>
<tr>
<td>Had Mononucleosis</td>
<td></td>
<td></td>
<td>Date of Diagnosis:</td>
</tr>
</tbody>
</table>

**PLEASE LIST OTHER MEDICAL CONDITIONS/ISSUES NOT LISTED ABOVE:**

1) 
2) 
3) 
4) 
5) 
6) 
7) 
8) 
9) 
10) 

CC: Tina Brinkman, RN/Nikki Al Khatib, RN
ALLERGIES & REACTIONS: Residential & Non-Residential Students

Please list all allergies & reactions
(medication/food/environmental/etc)

<table>
<thead>
<tr>
<th>Allergic To:</th>
<th>Reaction:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td></td>
</tr>
</tbody>
</table>

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)

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

PHYSICIAN INFORMATION: Residential & Non-Residential Students

(Please list all physicians your child sees including office & fax numbers)

Primary Care Physician/Provider (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 #: __________________

CC: Tina Brinkman, RN/Nikki Al Khatib, RN
INSURANCE INFORMATION: Residential & Non-Residential Students
(Please complete all blanks below)

Does your child have health insurance?  _____ Yes  _____ No  _____ Pending
Name of Insurance Company: _______________________________________________________
Name of Policy Holder: ___________________________________ Policy Holder’s DOB: ___________ Relationship: _______________
Is there a separate card for prescriptions?  _____ Yes  _____ No
Is your child covered by more than 1 (one) insurance company?  _____ Yes  _____ No

*If you answered “yes” to the last question above, please place the secondary insurance information below*

Name of Secondary Insurance Company: _______________________________________________________
Name of Policy Holder: ___________________________________ Policy Holder’s DOB: ___________ Relationship: _______________

PHARMACY: Residential Students
(Please mark at least 1 (one) pharmacy below)

FYI for returning students/families: The BSU Pharmacy has closed permanently and unfortunately is no longer an option.
• In the event your child becomes ill/injured while at school and needs a prescription filled, please check at least 1 (one) pharmacy below that you would like us to use along with a preferred method of payment.
• Please note…these 2 (two) pharmacies are the closest to the Indiana Academy and are the only pharmacies we will utilize.

__________  Walgreen’s Pharmacy:  2720 W. Jackson Street – Muncie, IN 47304 – (765) 287-8533
Payment Options:  Cash, Check, Credit/Debit/Health Savings Account Card or Express Pay.
Walgreen’s does not accept payment over the telephone.
PLEASE MARK A “METHOD OF PAYMENT” BELOW:

1.  _____ I, the parent/guardian, will provide a copy of a credit/debit card or a health savings account card
to the nursing staff for prescriptions.  If you choose this option, please feel free to provide a card
copy at either summer orientation or on move-in day.
2.  _____ I, the parent/guardian, will provide cash, credit/debit card or a health savings account card
to the student for prescriptions.
3.  _____ I, the parent/guardian, live close to the Indiana Academy and will fill all prescriptions for my child.

__________  CVS Pharmacy:  2729 W. Jackson Street – Muncie, IN 47304 – (765) 287-0074
Payment Options:  Cash, Check, Credit/Debit Card or Health Savings Account Card.
CVS does not accept payment over the telephone.
PLEASE MARK A “METHOD OF PAYMENT” BELOW:

1.  _____ I, the parent/guardian, will provide a copy of a credit/debit card or a health savings account card
to the nursing staff for prescriptions.  If you choose this option, please feel free to provide a card
copy at either summer orientation or on move-in day.
2.  _____ I, the parent/guardian, will provide cash, credit/debit card or a health savings account card
to the student for prescriptions.
3.  _____ I, the parent/guardian, live close to the Indiana Academy and will fill all prescriptions for my child.

CC:  Tina Brinkman, RN/Nikki Al Khatib, RN
### STUDENT QUESTIONS & SIGNATURE: Residential & Non-Residential Students

(Student...please answer all questions & sign below)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>I, a student at the Indiana Academy, received and read the fact sheet regarding <em>Concussion</em>. I understand the risk of concussion &amp; head injury, including the risks of continuing an activity/sport after a concussion or head injury (see FYI Form B page 1)? IC 20-34-7</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>I, a student at the Indiana Academy, received and read the fact sheet regarding <em>Sudden Cardiac Arrest</em> and understand the symptoms of cardiac arrest (FYI Form B page 1)? IC 20-34-8</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>I, a student at the Indiana Academy, received and read the <em>Overview of the Prescription Medication Policy</em>. I will ask questions if I do not understand the policy (FYI Form B page 4)?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Student Signature:** ___________________________ **Date:** ___________________________

### PARENT/GUARDIAN QUESTIONS & SIGNATURE:

* QUESTIONS 1–6: TO BE COMPLETED BY PARENT/GUARDIAN FOR ALL STUDENTS (residential & non-residential students):

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>I, the parent/guardian, received &amp; read both of the fact sheets regarding <em>Concussion &amp; Sudden Cardiac Arrest</em> (FYI Form B page 2)? I understand the nature &amp; risk of concussion/head injury, including the risks of continuing an activity/sport after a concussion/head injury, as well as the symptoms of sudden cardiac arrest?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>I, the parent/guardian, received &amp; read the <em>Meningitis Fact Sheet</em> (FYI Form B page 3)?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>I, the parent/guardian, received &amp; read the <em>Overview of the Prescription Medication Policy</em> (FYI Form B page 4)?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>I, the parent/guardian, understand that I am responsible for submitting a complete and up-to-date copy of my child’s <em>Immunization Record</em> to the nurse’s office by the first day of class (FYI Form B page 4)?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>I, the parent/guardian, understand that pertinent medical information on my child may be relayed to appropriate faculty/staff/administration?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>I, the parent/guardian, give consent for my child to participate in &amp; provide a blood donation during our IASMH blood drives (do not need consent for students 17 years and older)?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* QUESTIONS 7–10: TO BE COMPLETED BY PARENT/GUARDIAN FOR 11TH & 12TH RESIDENTIAL STUDENTS:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.</td>
<td>I, the parent/guardian, authorize &amp; 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 or injury?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 8. | I, the parent/guardian, give consent for the IASMH 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? |   |   |   |   |

* QUESTION 11: TO BE COMPLETED BY PARENT/GUARDIAN FOR ALL 11TH GRADE (or younger) STUDENTS (residential & non-residential):

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>
| 11. | 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 registry is used to verify your child has received proper immunizations according to the recommended immunization schedule.  
  * 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 a registry in 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 IC 16-38-3.  
  * Other than the immunization record/exemptions/allergies, the following information may be needed for CHIRP: student’s name, date of birth, address, phone number & parent/guardian name.* |   |   |   |   |

**Parent Signature:** ___________________________ **Date:** ___________________________

**CC:** Tina Brinkman, RN/Nikki Al Khatib, RN
### PHYSICIAN/PRESCRIBER CONSENT FOR SELF-ADMINISTRATION OF PRESCRIPTION MEDICATION

**Residential & Non-Residential Students**

- This section MUST be completed by the prescriber (not the parent/guardian)
  - One page per Prescriber – please complete all columns
- Prescription medication includes: oral medication including birth control pills, insulin, epipens, inhalers, nasal sprays, topical creams/lotions/gels & eye/ear drops
- Note…per school policy, “controlled” medication is not permitted in student dorm rooms & therefore is not allowed to be self-administered (even if marked “yes” below)

<table>
<thead>
<tr>
<th>Medication (name/dosage/route/frequency)</th>
<th>As Needed? (please circle)</th>
<th>Diagnosis</th>
<th>Consent for Self Administration (please circle)</th>
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**Physician/Prescriber:**

Provider Signature: ____________________________________________ Printed Name: ____________________________

Address: ____________________________________________________________________________________________

Phone #: ____________________________ Fax #: ____________________________ Date: ____________________________

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### PARENT CONSENT FOR SELF-ADMINISTRATION OF PRESCRIPTION MEDICATION

**Residential & Non-Residential Students**

- One page per Prescriber
- Please see “FYI Page 4” for an overview of our medication policy

I, the parent/guardian, give consent for my child to self-administer the above medication in compliance with the Indiana Academy Medication Policy? __________ YES __________ NO (If there are meds you do not want your child to self-administer, please list those medications here):

Parent/Guardian Signature: ____________________________________________

Printed Name: __________________________________ Date: ____________________________

---

CC: Tina Brinkman, RN/Nikki Al Khatib, RN
ASTHMA ACTION PLAN: Residential & Non-Residential Students

- This page is required **ONLY** if your child has a current diagnosis of Asthma
- This section MUST be completed by the Asthma Care Provider (not the parent/guardian)

**Student’s Name:** ____________________________

**Asthma Care Provider Information:**
Asthma Care Provider Name: __________________________________________________________

Phone #: ___________________________ Fax #: ___________________________ Email Address: ___________________________

**Daily Controller Medication/Inhalers:**
1. 
2. 
3. 
4. 

**Rescue (quick-relief) Medication/Inhaler:**
1. 
2. 

**Nebulizer:** _____ YES _____ NO
1. 

**Action Plan:**
1. Continue Daily Controller Medications (if prescribed).
2. Use rescue inhaler or nebulizer every _____ hours as needed for asthma symptoms.
   - Stay with student.
   - Recheck symptoms after 10 minutes.
3. If no improvement, contact parent/guardian for further instructions.
4. Call 911 immediately if:
   - Unable to reach parent/guardian.
   - Child is struggling to breathe & there is no improvement after using rescue inhaler.
   - Lips & fingernails are blue or gray.
   - Trouble walking & talking due to shortness of breath.
   - Loss of consciousness.
5. May repeat rescue medication every 10 minutes if symptoms do not improve, until medical assistance has arrived or child is in the Emergency Department.

**Please list other information/instructions here:**
1. 
2. 
3. 
4. 

**Please check all that apply:**
_____ Student can carry & use his/her inhaler at school without supervision
_____ Student needs supervision or assistance to use his/her inhaler medication at school

**Asthma Care Provider Signature**  **Provider Printed Name**  **Date**

I, the parent/guardian, 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 the prescribed medication and delivery/monitoring devices:

**Parent/Guardian Signature**  **Parent/Guardian Printed Name**  **Date**

**CC:** Tina Brinkman, RN/Nikki Al Khatib, RN
DIABETES ACTION PLAN: Residential & Non-Residential Students

- This page is required **ONLY** if your child has a current diagnosis of Diabetes OR provide your own action plan
- This section MUST be completed by the Diabetes Care Provider (not the parent/guardian)

**Student’s Name:** _____________________________________________

**Diabetes Care Provider Information:**

Diabetes Care Provider Name: ______________________________________

Phone #: __________________Fax #: ___________________ Email Address: ______________________________

☐ Type 1  ☐ Type 2  ☐ Insulin Pump?  ☐ Yes  ☐ No  Blood Glucose Target Range: ________________________

**Blood Sugar Testing Times** (check all that apply): _____ before all meals _____ at bedtime _____ other: ______

**Diabetes Medication:**

Long Acting Insulin: _____ YES     _____ NO Name/Dosage/Frequency of Long Acting Insulin: ______________________

Short Acting Insulin: _____ YES     _____ NO Name/Dosage/Frequency of Short Acting Insulin: ______________________

Corrective Dose Scale/Calculation: ___________________ When to use scale/calculation? ______________________

Food Dose Scale/Calculation: ___________________ When to use scale/calculation? ______________________

Oral Medication: _____ YES     _____ NO Name/Dosage/Frequency of Medication: ______________________

**Exercise/Sport Activity:**

May participate in PE classes?  ____ YES ____ NO  May participate in after school sports?  ____ YES ____ NO

Snack should be eaten if blood glucose is under _______.  Exercise should be delayed if BG is higher than _____ or lower than _____

**Hypoglycemia:** Hypoglycemia is a blood sugar less than __________.

☐ Give immediate sugar source (4 glucose tablets, ½ cup fruit juice or regular pop, 1 fruit rollup, 5-6 lifesavers or glucose gel).

☐ If blood sugar is less than 50 give 2 sugar source treatments.

☐ Wait 15-20 minutes.  Re-test & re-treat until blood sugar is in target range.

☐ If low before a meal/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.

**Hypoglycemia/Treatment for Unconscious/Seizing Student:**

☐ Administer Glucagon  ☐ 1 Vial  ☐ ½ Vial

☐ Call 911.

☐ Test blood sugar every 10 minutes.

☐ If student arouses prior to EMS arriving, give sips of regular soda and crackers.

☐ Do not give any liquids or food while unresponsive.

☐ Notify parent/guardian.

**Hyperglycemia:** Hyperglycemia is a blood sugar greater than __________.

☐ If blood sugar is greater over ________ check urine for ketones.

☐ Allow unrestricted bathroom privileges.

☐ Encourage extra sugar free liquids (water, diet drinks).

- Negative/Trace/Small Ketones:  8-12 oz every ½ to 1 hour (inform parent/guardian for trace/small ketones).

- Moderate/Large Ketones: Notify parent/guardian and/or Diabetes provider.

☐ Student should NOT participate in exercise-related activities.

☐ Call parent/guardian and/or Diabetes provider if vomiting occurs.

**Comments/Special Instructions:**

________________________________________________

_________________________________ ____________________

DIABETES CARE PROVIDER SIGNATURE  PROVIDER PRINTED NAME  DATE

I, the parent/guardian, 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 the prescribed medication and delivery/monitoring devices:

________________________________________________

_________________________________ ____________________

PARENT/GUARDIAN SIGNATURE  PARENT/GUARDIAN PRINTED NAME  DATE

CC:  Tina Brinkman, RN/Nikki Al Khatib, RN
SEIZURE ACTION PLAN: Residential & Non-Residential Students

- This page is required ONLY if your child has a current diagnosis of Seizures/Epilepsy OR provide your own action plan
- This section MUST be completed by the Seizure Care Provider (not the parent/guardian)

Student’s Name: ____________________________________________________________

Seizure Care Provider Information:
Seizure Care Provider Name: ________________________________________________
Phone #: __________________ Fax #: __________________________ Email Address: __________________________

Seizure Information: Type: ______________________ Triggers/Warning Signs: ____________________________

Daily, As-Needed & Emergency Seizure Medication (name/dosage/frequency):
1. 
2. 
3. 
4. 

Does the student have a Vagus Nerve Stimulator?  □ Yes  □ No
If YES, describe magnet used:

Action Plan:
1. Stay Calm & track time of seizure (start & end time).
2. Keep child safe.
3. Do not restrain.
4. Do not put anything in mouth.
5. Stay with child until fully conscious.
6. Student may return to the classroom following a seizure as long as fully alert/oriented without any lingering effects from the seizure.
7. Call 911 for a seizure emergency
   • Convulsive (tonic-clonic) seizure that lasts longer than 5-10 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.
8. Administer emergency medication as indicated above.

Comments/Special Instructions:

________________________________________________  ___________________________

SEIZURE CARE PROVIDER SIGNATURE  PROVIDER PRINTED NAME  DATE

I, the parent/guardian, 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 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 the prescribed medication and delivery/monitoring devices:

________________________________________________  ___________________________

PARENT/GUARDIAN SIGNATURE  PARENT/GUARDIAN PRINTED NAME  DATE

CC:  Tina Brinkman, RN/Nikki Al Khatib, RN
SEVERE ALLERGY & ANAPHYLAXIS ACTION PLAN: Residential & Non-Residential Students

- This page is required **ONLY** if your child has a current diagnosis of Severe Allergies OR provide your own action plan (ESPECIALLY IF PRESCRIBED EPINEPHRINE)
- This section MUST be completed by the Allergy Care Provider (not the parent/guardian)

**Student’s Name:** ______________________________________________________________

**Allergy Care Provider Information:**
Allergy Care Provider Name: _____________________________ Fax #: _________________________ Email Address: __________________________

**Extremely Reactive to the Following Allergens:**
1. ____________________________________________________________ 3. ____________________________________________________________ 5. ____________________________________________________________
2. ____________________________________________________________ 4. ____________________________________________________________ 6. ____________________________________________________________

**Medications:**

<table>
<thead>
<tr>
<th>Medication Name:</th>
<th>Dosage:</th>
<th>Special Instructions/Directions:</th>
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</thead>
<tbody>
<tr>
<td>Epinephrine</td>
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<td>□ 0.15mg  OR □ 0.30mg</td>
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<td></td>
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<tr>
<td>Antihistamine</td>
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<td>□ Claritin □ Zyrtec</td>
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<td>□ Allegra □ Benadry</td>
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<td>□ Other</td>
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<tr>
<td>Inhaler</td>
<td>1.</td>
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<td>2.</td>
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<tr>
<td>Other</td>
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</table>

**Action Plan:**
1. If Epinephrine is prescribed, please check at least one of the following:
   - □ If checked, give epinephrine immediately if the allergen was **LIKELY** eaten, for ANY symptoms.
   - □ If checked, give epinephrine immediately if the allergen was **DEFINITELY** eaten, even if no symptoms are apparent.
2. Inject Epinephrine (if prescribed).
3. Call 911 if Epinephrine used. Request an ambulance with Epinephrine.
4. Give additional medications if prescribed (if conscious & able to swallow).
   - Antihistamines
   - Inhaler
5. Lay student flat & raise legs. If breathing is difficult or student is vomiting, let him him/her sit up or lie on side.
6. If symptoms do not improve or symptoms return, more doses of Epinephrine can be given at least 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.

**Comments/Special Instructions:**

________________________________________________

____________________________________ ____________________

ALLERGY CARE PROVIDER SIGNATURE PROVIDER PRINTED NAME DATE

I, the parent/guardian, 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 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 the prescribed medication and delivery/monitoring devices:

________________________________________________

____________________________________ ____________________

PARENT/GUARDIAN SIGNATURE PARENT/GUARDIAN PRINTED NAME DATE

CC: Tina Brinkman, RN/Nikki Al Khatib, RN
RELIGIOUS EXEMPTION TO VACCINATION (S): Residential & Non-Residential Students

- The top portion of this page is required ONLY if your child has a religious exemption to any vaccine

Student’s 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):

- Hepatitis A
- Hepatitis B
- Chicken Pox/Varicella
- Measles/Mumps/Rubella (MMR)
- Meningitis (MCV4 or Men B)
- Polio (OPV or IPV)
- Tetanus/Diphtheria/Pertussis (Dtap/DT/TD/Tdap)

- 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 ___________________________ Parent/Guardian Printed Name ___________________________ Date ___________________________

MEDICAL EXEMPTION TO VACCINATION (S): Residential & Non-Residential Students

- This portion of the page is required ONLY if your child has a medical exemption to any vaccine

Student’s Name: ___________________________ Date of Birth: ___________________________

Physician: please complete all columns below in order to exempt this student from school immunization requirements:

<table>
<thead>
<tr>
<th>Name of Exempted Vaccine</th>
<th>Reason for Exemption</th>
<th>Permanent or Temporary Exemption (please circle)</th>
<th>Date the Temporary Exemption Ends (if applicable)</th>
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Please place any additional information/comments here:

Physician Signature: ___________________________ Printed Name: ___________________________ Date: ___________________________

Address: _________________________________________________________________________________________

Phone #: ___________________________ Fax #: ___________________________ Office Email: ___________________________

CC: Tina Brinkman, RN/Nikki Al Khatib, RN
What is a Concussion?
A concussion is a brain injury that:
- Is caused by a bump, blow, or jolt to the head or body
- Can change the way your brain normally works
- Can occur during practices or games in any sport or recreational activity
- Can happen even if you haven’t been knocked out
- Can be serious even if you’ve just been “dinged” or “had your bell rung”

What are the symptoms of a Concussion?
- Headache or “pressure” in head
- Balance problems or dizziness
- Bothered by light or noise
- Feeling sluggish, hazy, foggy, or groggy
- Nausea or vomiting
- 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?
1. Use the proper sports equipment, including personal protective equipment. In order for the equipment to protect you, it must be:
   - The right equipment for the game, position, or activity
   - Worn correctly and the correct size and fit
   - Used every time you play or practice
2. Follow your coach’s/slcs’s rules for safety and the rules of the sport
3. Practice good sportsmanship

If you think you have a concussion:
- Don’t hide it
- Report it
- Take time to recover

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
- Racing or irregular heartbeat
- Unusual shortness of breath
- 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 an athlete does not look or feel right and you are just not sure
- 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

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 use 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/slcs, 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 December 5, 2018
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 think your teen has one or more symptoms of concussion, get medical attention right away.

**Signs Observed by Parent/Guardian:**
- Appears dazed or stunned
- Is confused about assignment or position
- Forgets an instruction
- Is unsure of game, score, or opponent
- Moves clumsily
- Answers questions slowly
- Loses consciousness (even briefly)
- Shows mood, behavior, or personality changes
- Can’t recall events prior to hit or fall
- Can’t recall events after hit or fall

**Symptoms Reported by Student:**
- Headache or “pressure” in head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Sensitivity to light or noise
- Feeling sluggish, hazy, foggy, or groggy
- Concentration or memory problems
- Confusion
- Just not “feeling right” or is “feeling down”

**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 it fits properly, be well maintained, and be worn consistently and correctly.
- Ensure that they follow the 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 use 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.
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 separate vaccine for Meningitis Serogroup B. This vaccine is currently recommended but not required. The Meningitis B vaccine is a 2-shot series separated by at least 1 month. Both meningococcal vaccines are 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 December 5, 2018
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 (page 6).

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 (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 student. 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/mailbox or the Office of Student Life (front desk). The nurses 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. Please contact the nursing office if you have any questions at (765) 285-7360.

9. 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

<table>
<thead>
<tr>
<th>Vaccine</th>
<th># of Doses Required</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tetanus (Dtap/DTP/DT)</td>
<td>5</td>
<td>4 doses are acceptable ONLY if the 4th dose was administered on or after the 4th birthday, otherwise the student must have 5 doses.</td>
</tr>
<tr>
<td>Tdap (acellular pertussis)</td>
<td>1</td>
<td>All students in grades 6-12 must have 1 documented Tdap Vaccine.</td>
</tr>
<tr>
<td>Polio</td>
<td>4</td>
<td>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).</td>
</tr>
<tr>
<td>Measles/Mumps/Rubella (MMR)</td>
<td>2</td>
<td>2 Measles, 2 Mumps &amp; 1 Rubella Vaccines are acceptable in place of 2 MMR Vaccines.</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>3</td>
<td>All students must have 3 documented Hepatitis B Vaccines.</td>
</tr>
<tr>
<td>Varicella (chicken pox)</td>
<td>2</td>
<td>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 &amp; year of the disease).</td>
</tr>
<tr>
<td>Meningitis (MCV4)</td>
<td>1 (junior year)</td>
<td>1 dose is required for your junior year. A booster dose (or 2nd dose) is required for your senior year.</td>
</tr>
<tr>
<td></td>
<td>2 (senior year)</td>
<td></td>
</tr>
<tr>
<td>Hepatitis A</td>
<td>2 (senior year)</td>
<td>All students in grade 12 must have 2 documented Hepatitis A Vaccines.</td>
</tr>
</tbody>
</table>

Indiana Vaccine Recommendations: Annual Influenza
- 2 doses of Men B (Meningococcal B) Vaccine
- 3 doses of HPV Vaccine

This page was last reviewed December 14, 2018