MR. JEFF WEISS, ED.D
DISTRICT ADMINISTRATOR

MS. GENA SANTHARAM
PRINCIPAL/DIRECTOR OF PUPIL SERVICES

Medication Authorization and Medical Forms

Attention - The following pages should only be filled out if your child has a special medical need.

If your child has an allergy, is diabetic, has seizures, or suffers from asthma, there are special forms enclosed for you to complete. If your child takes a prescribed medication, please fill out the Authorization of Medication For Students form and have your doctor sign it in the appropriate space. If your child will be bringing an Epi-Pen or an inhaler to school, you will also need to fill out the enclosed Parent Consent Form for Student's Use/Possession of Medication form. We suggest that if your child will be bringing an Epi-Pen to school, that it be kept in the Health Room. This way we have a record of your child's allergy, along with the pen, and will not have to search through classrooms or backpacks to find this life saving piece of equipment. **If a student should show signs of anaphylaxis and does not have a prescribed Epi-Pen on site, 911 will be called for emergency treatment.** We also suggest that if your child will be bringing an inhaler to school, and you would like them to keep it with them at all times, that you also send an inhaler to be kept in the Health Room. We have had several incidents where a child had misplaced their inhaler and having a spare one in the Health Room saved unnecessary emergency trips for mom or dad. Last, if you intend to bring Ibuprofen, Benadryl, Cough Drops or any other over the counter medicines to school for your child, please fill out the Authorization of Medication For Students form, and sign in the appropriate space. **All medications must be in the package that they were purchased in and must be clearly marked with the student's first and last names. Students may not transport medications. No medication (including Tylenol, Aspirin, cough drops, or any commercial health product) may be kept with a student, in a student's locker or backpack.** After you have correctly filled out your forms, you may bring the forms and medications to school during Fall Registration.

We will not accept forms without the medications, nor medications without the forms.
MAKE SURE YOU HAVE YOUR DOCTOR'S SIGNATURE FOR ALL PRESCRIBED MEDICATIONS.

If you have your paperwork filled out correctly, and you have your medications available, you may bring them to registration and we will keep them under lock and key in the Health Room for the 2018-2019 school year.
If you have any questions regarding medications, illnesses or medical forms, please call us at (262) 538-1360.

Thank you,

The Richmond Office/Health Room Staff

Richmond School District
N56 W26530 Richmond Road - Sussex, WI 53089
Phone (262) 538-1360 Fax (262) 538-1572

AUTHORIZATION OF MEDICATION FOR STUDENTS
(Not to be used for students with Asthma or Epi Pen plans)

Please print or type:
Student Name ______________________________ Parent/Guardian ______________________________

Home Phone __________________ Work Phone __________________ Cell __________________

Teacher ______________________ Grade _______ Birthdate _______________ ☐ Male ☐ Female

Physician's Name ______________________________ Physician's Phone Number __________________

Name of Medication ______________________ Strength __________ Dose __________________

FORM: ☐ Tablet ☐ Capsule ☐ Liquid ☐ Ointment ☐ Cream ☐ Lotion ☐ Inhaler ☐ Other

Time of day to be given__________ or /every ______hrs. Dates to be given ______________________

If medication is being given "WHEN NEEDED," describe indications: ______________________________

____

Special instructions: ____

PHYSICIAN SIGNATURE NEEDED FOR PRESCRIPTION MEDICATION ONLY

TO THE PHYSICIAN: According to the State of Wisconsin Medical Examining Board and the Richmond School District's *Administrative Guidelines for Dispensing Prescription and Nonprescription Medication to Students*, it is requested that you complete this form before school personnel may dispense or administer **Prescription** medication. By signing this form, you indicate a willingness to accept direct communication from the person dispensing or administering the medication.

PHYSICIAN'S SIGNATURE ______________________________________ DATE __________________

TO THE PARENT/GUARDIAN: By signing below, you request and authorize that your son/daughter can be assisted in taking the medication described above at school by designated school staff.

PARENT/GUARDIAN SIGNATURE ______________________________________ DATE __________________

PARENTS/GUARDIANS ARE RESPONSIBLE FOR DELIVERING MEDICATIONS TO SCHOOL IN ORIGINAL CONTAINER. STUDENTS ARE NOT ALLOWED TO BRING MEDICATIONS TO SCHOOL – ONLY PARENTS/GUARDIANS !

DEPARTMENT OF HEALTH SERVICES
Division of Public Health
P-44021 (Rev. 07/13)

STATE OF WISCONSIN
s. 252.04, Wis. Stats.

STUDENT IMMUNIZATION LAW
AGE/GRADE REQUIREMENTS
2014 SCHOOL YEAR and Beyond

The following are the minimum required immunizations for each age/grade level. It is not a recommended immunization schedule for infants and preschoolers. For that schedule, contact your doctor or local health department.

Age/Grade	Number of Doses					
Pre K (2 yrs through 4 yrs)	4 DTP/DTaP/DT[2]		3 Polio	3 Hep B	1 MMR[5]	1 Var[6]
Grades K through 5	4 DTP/DTaP/DT/Td[1,2]		4 Polio[4]	3 Hep B	2 MMR[5]	2 Var[6]
Grades 6 through 12	4 DTP/DTaP/DT/Td[2]	1 Tdap[3]	4 Polio[4]	3 Hep B	2 MMR[5]	2 Var[6]

1. DTP/DTaP/DT vaccine for children entering **Kindergarten**: Your child must have received one dose after the 4th birthday (either the 3rd, 4th, or 5th dose) to be compliant. (Note: a dose 4 days or less before the 4th birthday is also acceptable).
2. DTP/DTaP/DT/Td vaccine for all students Pre K through 12: Four doses are required. However, if your child received the 3rd dose after the 4th birthday, further doses are not required. (Note: a dose 4 days or less before the 4th birthday is also acceptable).
3. Tdap means adolescent tetanus, diphtheria and acellular pertussis vaccine. If your child received a dose of a tetanus-containing vaccine, such as Td, within 5 years of entering the grade in which Tdap is required, your child is compliant and a dose of Tdap vaccine is not required.
4. Polio vaccine for students entering grades Kindergarten through 12: Four doses are required. However, if your child received the 3rd dose after the 4th birthday, further doses are not required. (Note: a dose 4 days or less before the 4th birthday is also acceptable).
5. The first dose of MMR vaccine must have been received on or after the first birthday (Note: a dose 4 days or less before the 1st birthday is also acceptable).
6. Var means Varicella (chickenpox) vaccine. A history of chickenpox disease is also acceptable.

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RICHMOND SCHOOL IMMUNIZATION NOTIFICATION

Dear Parent:

Before your child enters kindergarten this Fall, please be aware that the Wisconsin Immunization Law requires a booster dose of Varicella (chickenpox) vaccine or a history of the child having had chickenpox. Although thought by some to be a harmless disease, Varicella can result in serious complications including bacterial skin infections; Reye Syndrome (a neurologic disorder), encephalitis, and meningitis can be fatal.

Also, please be aware that one dose of DTaP vaccine is required after the 4th birthday. For children who are "up to date" with their preschool DTaP series this will be the final (5th) dose that is recommended to ensure prolonged protection, primarily against pertussis also known as whooping cough. For children who are not "up to date" this dose may be the 3rd or 4th in a series and no further doses are required. Because of the 4-day grace period, DTaP vaccine received 4 days or less before the 4th birthday is also acceptable.

The date (month, day, and year) of each immunization must be entered on the Student Immunization Record that is available from your child's school and should be submitted to the school your child will attend.

Waivers are acceptable for religious, health, and personal conviction reasons. However, in the event of an outbreak of a vaccine preventable disease, students with waivers may be excluded from school until the outbreak subsides.

You are encouraged to have your child immunized well in advance of school opening to avoid the late summer rush at immunization clinics. For immunizations, contact your doctor, clinic, HMO or nearest public health department.

You may view your child's immunization record from your computer on the Wisconsin Immunization Registry (WIR). The WIR is a secure computerized data system that tracks immunizations given to people. The internet address is HYPERLINK "http://dhfsWIR.org" http://dhfsWIR.org. To obtain the dates of your child's immunizations, type in your child's name, social security or Medicaid number. In order to access your child's record, their social security number must be in the system. If it is not, contact your medical provider and ask that the number be put into the WIR so that you can access your child's immunization record. Address information about your child is not provided.

If you would like further information on immunizations, please see the following websites: HYPERLINK "http://www.cdc.gov/vaccines/" http://www.cdc.gov/vaccines/, HYPERLINK "http://www.immunize.org/" http://www.immunize.org/ and HYPERLINK "http://dhs.wisconsin.gov/immunization/index.htm" http://dhs.wisconsin.gov/immunization/index.htm

Thank you.

SHOULD YOU HAVE ANY QUESTIONS, PLEASE CONTACT YOUR CHILD'S DOCTOR

RICHMOND SCHOOL DISTRICT — N56 W26530 RICHMOND ROAD — SUSSEX, WI 53089
PHONE: 262-538-1360 — FAX: 262-538-1572 — RICHMOND.K12.WI.US

DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-04020L (Rev. 08/10)

STATE OF WISCONSIN
252.04 and 120.12 (16) Wis. Stats.

STUDENT IMMUNIZATION RECORD

INSTRUCTIONS TO PARENT: COMPLETE AND RETURN TO SCHOOL WITHIN **30 DAYS AFTER ADMISSION.** State law requires all public and private school students to present written evidence of immunization against certain diseases **within 30 school days of admission.** The current age/grade specific requirements are available from schools and local health departments. These requirements can be waived only if a properly signed health, religious, or personal conviction waiver is filed with the school. The purpose of this form is to measure compliance with the law and will be used for that reason only. If you have questions on immunizations or how to complete this form, contact your child's school or local health department.

PERSONAL DATA — **PLEASE PRINT**

Step 1

Student's Name	Birthdate (Mo/Day/Yr)	Gender	School	Grade	School Year
Name of Parent/Guardian/Legal Custodian	Address (Street, City, State, Zip)			Telephone Number ( )	

IMMUNIZATION HISTORY

Step 2 List the MONTH, DAY AND YEAR your child received each of the following immunizations. DO NOT USE A (√) OR (X) except to answer the question about chickenpox. If you do not have an immunization record for this student at home, contact your doctor or public health department to obtain it.

TYPE OF VACCINE*	FIRST DOSE Mo/Day/Yr	SECOND DOSE Mo/Day/Yr	THIRD DOSE Mo/Day/Yr	FOURTH DOSE Mo/Day/Yr	FIFTH DOSE Mo/Day/Yr
DTaP/DTP/DT/Td (Diphtheria, Tetanus, Pertussis)					
Adolescent booster (Check appropriate box) ☐ Tdap ☐ Td					
Polio					
Hepatitis B					
MMR (Measles, Mumps, Rubella)					
Varicella (Chickenpox) Vaccine Vaccine is required only if your child has not had chickenpox disease. See below:					
Has your child had Varicella (chickenpox) disease? Check the appropriate box And provide the year if known: ☐ YES ______ year (Vaccine not required) ☐ NO or Unsure (Vaccine required)					

REQUIREMENTS

Step 3 Refer to the age/grade level requirements for the current school year to determine if this student meets the requirements.

COMPLIANCE DATA

Step 4

STUDENT MEETS ALL REQUIREMENTS
Sign at Step 5 and return this form to school.
__________Or__________________________________)

STUDENT DOES NOT MEET ALL REQUIREMENTS

Check the appropriate box below, sign at Step 5, and return this form to school. PLEASE NOTE THAT INCOMPLETEY IMMUNIZED STUDENTS MAY BE EXCLUDED FROM SCHOOL IF AN OUTBREAK OF ONE OF THESE DISEASES OCCURS.

☐ Although my child has NOT received ALL required doses of vaccine, the FIRST DOSE(S) has/have been received. I understand that the SECOND DOSE(S) must be received by the 90th school day after admission to school this year, and that the THIRD DOSE(S) and FOURTH DOSE(S) if required must be received by the 30th school day next year. I also understand that it is my responsibility to notify the school in writing each time my child receives a dose of required vaccine.

NOTE: Failure to stay on schedule and notify the school may result in court action and a fine of up to $25.00 per day of violation.

WAIVERS (List in Step 2 above, the date(s) of any immunizations your child has already received)

☐ **For health reasons** this student should not receive the following immunizations______________

______________________ ______________________
SIGNATURE - Physician Date Signed

☐ **For religious reasons** this student should not be immunized.

☐ **For personal conviction reasons** this student should not be immunized.

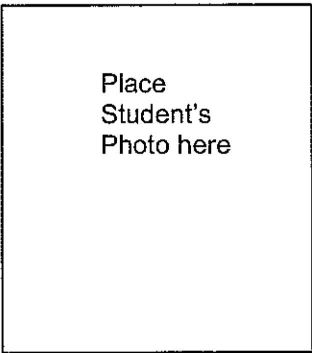
____
LIST VACCINE(S) WAIVED

SIGNATURE

Step 5 This form is complete and accurate to the best of my knowledge. By signing this form I give permission to share my child's immunization records with the Wisconsin Immunization Registry and my Immunization Provider for the purpose of maintaining a complete and accurate record to assist in assuring full immunization. Check here if you do not give your permission ☐

______________________ ______________________
SIGNATURE - Parent/Guardian/Legal Custodian or Adult Student Date Signed

Richmond School www.richmond.k12.wi.us
N56 W26530 Richmond Road Sussex, WI 53089
262-538-1360 Fax 262-538-1572



FORM A: ALLERGY ACTION PLAN - EMERGENCY CARE PLAN

Student Name ________________________ **D.O.B.** ______ **Weight** ______

Doctor's Name ________________________ **Phone #** ______________

Preferred Hospital ____________________________________

History of Asthma O No **O Yes-Higher risk for severe reaction***

ALLERGY:

Foods (list) ____

Has your physician recommended classroom and/or cafeteria (ex: peanut free table) modifications to ensure your child's safety? YES__ NO__

Stinging insects (list) ____

Medications (list) ____

Latex: Circle one Type I (anaphylaxis) Type IV (contact dermatitis)

MEDICATIONS AND DOSAGE:

Epinephrine brand & dose: ____________________________________

Antihistamine brand & dose: ___________________________________

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

STEP 1: RECOGNITION AND TREATMENT

Chart to be completed by Health Care Provider ONLY		**Give CHECKED medication(s)**	
If food ingested or contact w/ allergen occurs:		Epinephrine	Antihistamine
No symptoms noted	**Call parent & continue to observe for:**		
Mouth	Itching, tingling, or swelling of lips, tongue, mouth		
Skin	Hives, itchy rash, swelling of the face or extremities		
Gut+	Nausea, abdominal cramps, vomiting, diarrhea		
Throat+	Tightening of throat, hoarseness, hacking cough		
Lung +	Shortness of breath, repetitive coughing, wheezing		
Heart+	Thready pulse, low blood pressure, fainting, pale, blueness		
Neuro+	Disorientation, dizziness, loss of conscience		
If SYMPTOMS PROGRESS OR INVOLVE MULTIPLE AREAS, USE EPINEPHRINE			

STEP 2: Call 911 when Epinephrine is administered

STEP 3: Give additional medications as instructed here: ______________________________
____

*Antihistamines & inhalers/bronchodilators cannot be depended on to treat a severe reaction (anaphylaxis).

STEP 4: Monitoring

Stay with student; alert healthcare professionals and parent. Tell rescue squad Epipen was given; request an ambulance with Epipen. Note time when Epipen was administered. A second dose of Epipen can be given 5 minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping student lying on back with legs raised. Treat student even if parents cannot be reached. See back/attached for auto-injection technique

May student self-administer and keep the Auto-Injector under his/her control in a place such as backpack, purse or pockets? _____ YES _____ NO If yes, list likely location to find Auto-Injector ___________________

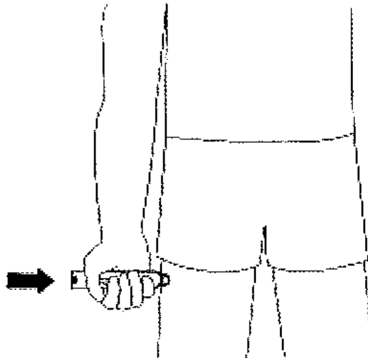
Back-up medication is stored at school: Yes__ No__

Parent/Guardian Signature ____________ **Date** ________ **Physician/Healthcare Provider Signature Date** ________

EpiPen® (epinephrine) Auto-Injector Directions

- First, remove the EpiPen® (epinephrine) Auto-Injector from the plastic carrying case
- Pull off the blue safety release cap

- Hold orange tip near outer thigh (always apply to thigh)



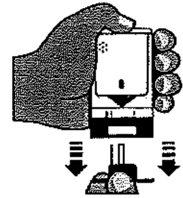
- Swing and firmly push orange tip against outer thigh. Hold on thigh for approximately 10 seconds.

Remove EpiPen® (epinephrine) Auto-Injector and massage the area for 10 more seconds.

EpiPen®, EpiPen 2-Pak®, and EpiPen Jr 2-Pak® are registered trademarks of Mylan Inc. licensed exclusively to its wholly-owned subsidiary, Mylan Specialty L.P.

Auvi-Q™ (epinephrine injection, USP) Directions

Remove the outer case of Auvi-Q. This will automatically activate the voice instructions.



Pull off RED safety guard.

Place black end against outer thigh, then press firmly and hold for 5 seconds.

Auvi-Q™
epinephrine injection, USP
0.15 mg/0.3 mg auto-injectors

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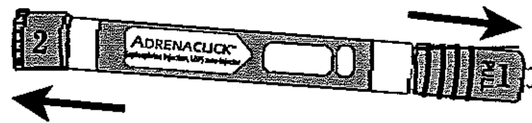
Adrenaclick® 0.3 mg and Adrenaclick® 0.15 mg Directions



Remove GREY caps labeled "1" and "2."

Place RED rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.

Richmond School
N56 W26530 Richmond Road, Sussex, WI 53089
262-538-1360 Fax 262-538-1572 www.richmond.k12.wi.us

FORM B: EPI-PEN OR INHALER USE & POSSESSION FORM
(not for over the counter medications)

Student's Name ______________________________ Grade ____________ School Year__________

PLEASE READ THE FOLLOWING OPTIONS AND MARK THE APPROPRIATE BOX BELOW.
SELECT OPTION 1, OPTION 2, or BOTH (if applicable):

OPTION 1

The medication is kept in the school health room. The student comes to the health room whenever medication is needed. The advantage to this option is that the use of the medication will be supervised and records will be kept as to the frequency of use. All medications brought to school must be in their original container with a current prescription label attached. In addition, the prescribing doctor must sign the applicable 'Asthma Care Plan' or 'FORM A: Allergy Action Plan and Emergency Care Plan'.

OPTION 2

The student carries the medication and uses it as prescribed. The student must have a doctor's permission noted in either the 'Asthma Action Plan' or 'FORM A: Allergy Action Plan and Emergency Care Plan' to use this option. The advantage of this option is that the medication is immediately accessible. It is recommended that extra medication be kept in the health room. Students who carry medications at school are expected sign the agreement below.

Student Agreement:

- ☐ I have been trained in the use of my auto injector and/or inhaler and understand the signs and symptoms when to use my prescription.
- ☐ I will notify a responsible adult (teacher, nurse, coach, etc.) **IMMEDIATELY** when an auto-injector (epinephrine) is used.
- ☐ I will go to theh health room if there is no improvement in my symptoms.
- ☐ I will not share my medications with other students.

Student Signature ____________________________ Date: ______________

Please note the location of where your child is planning to carry the noted medication, such as their backpack, purse, or pockets: ____

I choose: ☐ **Option 1** as described above for my child.

☐ **Option 2** as described above for my child.

Parent/Guardian Signature ______________________________ Date ______________

I give permission for my child to use the medication described below at school.
Staff members can be informed about my child's condition in order for my child to receive appropriate care.

Name of Medication	Dose	Frequency

Richmond School

N56 W26530 Richmond Road Sussex, WI 53089

262-538-1360 Fax 262-538-1572 www.richmond.k12.wi.us

FORM C: ALLERGY INFORMATION SHEET
FOR STUDENTS REQUIRING ALLERGY MEDICATION AT SCHOOL

Student's Name ______________________________ Home phone number ____________________

Date of Birth__________ Grade & Teacher ____________________ Weight_____/________date of form completion)

Parent/Guardian's Name ________________ Work phone number ____________ Cell Phone ________________

Parent/Guardian's Name ________________ Work phone number ____________ Cell Phone ________________

Other Emergency Contact____________________________ Ride the bus? Yes____ No_____ Route #________

Doctor's Name ______________________________ Doctor's phone number ______________________

ALLERGIC TO: (please include medications, foods, insects, latex, etc)

____

Asthmatic Yes* _____ NO _____ *High Risk for severe reaction

Health History

Do you believe your child would recognize if she/he were having an allergic reaction? Yes ____ No ____ Unsure ____

Has your child ever received epinephrine for a past allergic reaction? Yes ____ No ____ If so, please provide date:__________

*If so, were they transported to the hospital? Yes ____ No ____

Has your child ever used an antihistamine for relief of a past allergic reaction? Yes ____ No ____

Has your child ever needed to use an inhaler (bronchodilator) while experiencing an allergic reaction? Yes ____ No ____

Please list any other medications that have been used for past reaction(s) ______________________________

Please circle all symptoms that your child has experienced in past reactions.

Skin: Itching, Rash, Hives, Swelling of the Face, Swelling of the Extremities

Eyes: Watery eyes, Red eyes, Itchy Eyes,

GI: Nausea, Abdominal Cramps/Pain, Vomiting, Diarrhea

Mouth: Itchy /Scratchy Lips/ Mouth /Tongue , Swelling of Lips/Mouth /Tongue

Throat: Itching, Hoarseness, Cough, Sense of Tightness in Throat, Swelling/Closing of Throat, Difficulty Swallowing

Lungs: Shortness of Breath, Wheezing, Repetitive Coughing

Heart: Low Blood Pressure, Dizziness, Irregular heartbeat, Faintness /Loss of Consciousness, Flushed or Pale skin, Shock

Miscellaneous: Change in Voice, Mental Status Change

Please describe any past reactions and note any words or phrases your child may use to describe the allergic reaction.
List approximate age when reaction occurred.

____

____

____

TREATMENT PLAN

Richmond's trained staff will be following the **FORM A: ALLERGY ACTION PLAN –EMERGENCY CARE PLAN.** This form needs to be completed by your child's health care provider. Please contact the Health room when any medical changes occur for your child.

Has your physician recommended classroom modifications to ensure your child's safety? Yes____ No____

If yes, please specify:____

____

Richmond's Allergic Action Protocol:

1. Faculty will call the health room personnel to report reaction.
2. Follow procedures from **FORM A: Allergy Action Plan - Emergency Care Plan Sheet** (all students with epinephrine at school need this form on file in the health room).*This form is a comprehensive guide on when to use epinephrine, antihistamine, additional medication and when to call 911.
3. Administer any additional medications physician ordered-this should be included on the **FORM A: Allergy Action Plan - Emergency Care Plan** under the heading of medication/other.
4. Administer **CPR** if necessary.

Parental Consent:

- I hereby give my permission for the health room personnel, office staff or authorized school personnel to give the medications to my child according to the directions stated above.
- I give permission to the school to contact the student's physician if needed.
- I further agree to hold the Richmond School District harmless in any or all claims arising from the administration of this medication or the performance of this procedure at school.
- I agree to notify the health room at the termination of this request or when changes in the below order is necessary.
- If my child requires the use of Epinephrine for an allergic reaction, 911 will be called immediately. My child will be transported to the nearest hospital, unless hospital preference is listed.

____.
Preferred Hospital name

______________ ____
Date Signature of Parent/Legal Guardian

Richmond School
DIABETIC CAREPLAN

Student: ______________________________ Date of Birth: ______________

Physician: ________________________ Physician Ph Number: ______________

Do we have your permission to call the above physician, should questions arise regarding your child's health care here at school ? ☐ Yes ☐ No

How long has your child had diabetes ? _______________

My child is able to calculate his/her own carbohydrates at meal and snack times. ☐ Yes ☐ No

My child is able to check his/her own blood sugars ☐ Yes ☐ No

My child is able to administer his/her own insulin ☐ Yes ☐ No
(It is school policy that all medications are to be administered in the health room and that all insulin must be double checked, even if self-administered by students)

*If you checked "no" to any of the above questions, please notify the school nurse consultant, so that arrangements can be made to assist your child with this during school hours.

Note: Injections will be self-administered by student, nurse, or trained school-employee. No school employee, except a health care professional is required to administer any drug to a pupil by means other than injection (WI ACT 334)

☐ My child uses injections for insulin administration

Type of insulin _______________
Time(s) of administration _____________________

Carbohydrates (15gms) Units eaten	=	Insulin Units to be injected
( )	=	( )
One (15gms)	=	______
Two (30 gms)	=	______
Three (45 gms)	=	______
Four (60 gms)	=	______
Five (75 gms)	=	______
Six (90 gms)	=	______
Seven (90 gms)	=	______

Correction dose (Additional insulin based on blood sugar readings)

______	to	______	=	______unit(s)
______	to	______	=	______unit(s)
______	to	______	=	______unit(s)
______	to	______	=	______unit(s)
______	to	______	=	______unit(s)
______	to	______	=	______unit(s)

- [ ] My child uses an insulin pump for insulin administration

Type of insulin_____________________

Pump Basal Rates:

Time__________	to______________	Rate ______________
Time__________	to______________	Rate ______________
Time__________	to______________	Rate ______________
Time__________	to______________	Rate ______________
Time__________	to______________	Rate ______________
Time__________	to______________	Rate ______________

Pump Bolus Rates (Additional insulin based on meals):

Carbohydrates (15gms) Units eaten	=	Pump setting
(______________________)	=	(____________________)
One (15gms)	=	____________________
Two (30 gms)	=	____________________
Three (45 gms)	=	____________________
Four (60 gms)	=	____________________
Five (75 gms)	=	____________________
Six (90 gms)	=	____________________
Seven (90 gms)	=	____________________

Correction dose (Additional insulin based on blood sugar readings)

______________	to ________________	=	__________	setting
______________	to ________________	=	__________	setting
______________	to ________________	=	__________	setting
______________	to ________________	=	__________	setting
______________	to ________________	=	__________	setting
______________	to ________________	=	__________	setting

All medication to be taken at school requires a completed Medication Administration Form.

My child's target range for blood sugars is ______________ to ______________.

School Treatment Plan for Diabetic Emergencies

Hypoglycemia (low blood sugar)

Symptoms: Dizziness, drowsiness, confusion, rapid breathing, nausea, headache, sweating, shakiness, poor coordination
Child's usual symptoms:____
If student is conscious give him/her sugar of food containing sugar (juice, hard candy, non-diet soda, glucose tablets)
Parents will provide ___________________ for low blood sugar treatment.
They will be kept ____.
If student does not respond to treatment within 10 minutes or is unable or unwilling to eat or drink----CALL 911.
If student is refusing or unable to swallow, squirt glucose gel (in health room) into the side of student's mouth and massage into gums.
Notify parents

Hyperglycemia

Symptoms: Thirst, increasing urination, confusion, irritability, lethargy, unable to concentrate, dry mucous membranes.
Child's usual symptoms:____

Have child drink water or diet beverage (NO SUGAR PRODUCTS OR FOOD)
Call parents and notify with blood sugar over ________________.
If child is unconscious or disoriented----CALL 911

I would like to be notified any time my child's blood sugar is:
Under____________
Over ____________

If I cannot be reached by phone and my child does not respond to the above medication and treatment, I give my permission for school staff to call the physician listed above and follow his/her instructions. If the physician orders hospitalization or my child is exhibiting symptoms of a medical emergency, my child will be transported to the nearest hospital. I also understand that school staff can and will be informed of my child's health concerns in order to provide safe, appropriate care.

Parent Signature:___________________________________ Date:____________

Richmond School District N56 W26530 Richmond Road – Sussex, WI 53089 262-538-1360 FAX 262-538-1572

RICHMOND SCHOOL--SEIZURE CARE PLAN

Student: ______________________ Date of Birth: ______________________

Physician: ______________________ Physician Ph. Number: ______________________

Do we have your permission to call the above physician should questions arise regarding your child's health here at school? ☐ Yes ☐ No

How long has your child been diagnosed with a seizure disorder? ______________________

I would describe my child's seizures as:

☐ Simple Partial -- Remains conscious, twitching or numb sensation, usually lasting less than 30 seconds.

☐ Complex Partial -- Altered consciousness, transient staring, feelings of unreality and detachment. May have hallucinations, unexplained feelings of fear, disrupted memory, teeth grinding, lip smacking, chewing, swallowing, scratching or pulling at buttons. Lasts usually no longer than 1-2 minutes.

☐ Tonic-Clonic -- Abrupt arrest of activity, loss of consciousness, symmetrical and rhythmical alterations of contraction and relaxation of major muscle groups. Ends suddenly in less than 5 minutes.

☐ Atonic -- Abrupt loss of postural tone, loss of consciousness, confusion, lethargy and sleep. (May just fall asleep suddenly; when laughing, the child may fall down.)

☐ Myoclonic -- Brief random contractions of a muscle group, may occur on one side of the body, no loss of consciousness.

☐ Absence -- Very brief periods of altered awareness, eyelids may flutter or twitch, blank facial expression, lasts 5-10 seconds but can occur repeatedly.

☐ Tonic -- Lack of movement, stiffening of the entire body musculature, arms flex, legs, neck and head extend. Peculiar, piercing cry, cyanosis (bluish coloring to skin), may temporarily stop breathing, increased salivation.

☐ Akinetic -- No movement, but muscle tone is maintained. Like "freezing into position," may lose consciousness.

My child ☐ does ☐ does not have an aura before his/her seizures. (An aura is a sensation just before a seizure happens -- may be a sound, sight, smell, feeling -- they usually can tell if a seizure is about to happen.) If so, what is the aura? ______________________

RICHMOND SCHOOL TREATMENT PLAN FOR SEIZURES

Treatment:

- Assist the student to the floor, if needed. Lie on left side.
- DO NOT put anything between teeth or in mouth.
- DO NOT restrain.
- Clear area to protect student from injury.
- Start a written record of the seizure behavior and treatment including length of seizure activity.
- Notify parents.
- CALL 9-1-1 IF: seizure activity is different from "usual seizure activity" documented below, child's breathing is affected, it lasts longer than five (5) minutes or child fails to regain consciousness after seizure activity has stopped.
- Child's usual seizure activity includes: ______________________________
- ______________________________
- ______________________________
- Should the seizure activity last longer than ____________________, 9-1-1 should be called. (Please note: 9-1-1 will be called by school staff for any seizure activity lasting five (5) minutes.)

After seizure:

- Permit student to rest.
- Continue to document the episode.
- Monitor for second episode.
- Monitor for confusion or lack of consciousness.

If I cannot be reached by phone and my child does not respond to the above medication and treatment, I give my permission for school staff to call the physician listed on front side of care plan and follow his/her instructions. If the physician orders hospitalization or my child is exhibiting symptoms of a medical emergency, my child will be transported to the nearest hospital. I also understand that school staff can and will be informed of my child's health concerns in order to provide safe, appropriate care.

______________________________ ______________________________

Parent/Guardian Signature Date

Questions and Answers about the "Meningitis Vaccine" and Meningococcal Meningitis

In 2005, the Advisory Committee on Immunization Practices (ACIP) recommended that children receive the new meningococcal vaccine (Menactra) at their routine 11-12 year old doctor's visits and that for the next two to three years, teens entering high school should also be vaccinated.

This vaccine will protect against four of the types of meningococcal, including 2 of the 4 types most common in the U.S. Meningococcal vaccines cannot prevent all types of the disease. College freshman living in dormitories should consider receiving the vaccine due to their slightly elevated risk of acquiring the disease.

What is meningococcal meningitis ?
Meningococcal meningitis is a severe form of meningitis (inflammation of the meninges, the tissues that cover the brain and spinal cord) caused by the bacterium *Neisseria meningitides.*
Meningococcemia is an infection of the blood with *Neisseria meninitidis.*
A person may have either meningococcal meningitis or meningococcemia, or both at the same time.

What are the symptoms ?
Usual symptoms include sudden onset of fever, headache, stiff neck, vomiting and a rash.
It may also include sensitivity to light, sleepiness or confusion.

How soon do the symptoms appear ?
The symptoms may develop rapidly, sometimes in a matter of hours, but usually over the course of 1-2 days. In some cases, death may occur within hours of the onset of symptoms. The symptoms may appear anytime between 2-10 days after exposure, but usually within 3-4 days.

How are the bacteria spread ?
The meningococcus bacteria are spread by direct contact with respiratory and oral secretions on an infected person. A person with the disease may transmit the disease beginning several days before he/she becomes ill.

If you have any further questions about Meningitis and the "Meningitis Vaccine", please contact your child's physician.

Karen Peskie R.N.
Nurse Consultant