Health Information from your nurse and S.M. Schools

School Health Policies
Prairie Elementary

Dear Prairie Parents,

Your assistance with the following health policies will help keep students safe and healthy.

Illness: To protect your child and to prevent illness from spreading, please keep your child home if these symptoms are present:

- Diarrhea or vomiting
- Severe sore throat, headache, or cough
- Undiagnosed rash or skin lesions
- Redness or any drainage from the eye
- Temperature of 100.0 degrees or higher – Students should be free of fever, vomiting and/or diarrhea without medication for 24 hours before returning to school.

Absences: Call the school attendance line at **913-993-4488** to report that your child will be absent from school. Please let the school know why your child is absent – type of illness, appointments, travel, religious, etc. If the school is not notified of the absence, your child will be marked as unexcused.

Medication: The nurse's office will supply certain over-the-counter medications such as acetaminophen (Tylenol), ibuprofen (Advil), antacids, cough drops, anti-itch creams, and Benadryl. These medications can **ONLY** be given if the required "Over-The-Counter Medication Permission" form is on file. This form needs to be filled out and turned in to the office at the start of each school year.

P**rescription medications** should be brought directly to the nurse's office and must be accompanied by Rx Consent form which includes:

- **Parent** – Signature and instructions for administering the medication.
- **Physician** – Prescription medicine must be sent in a container exhibiting a current prescription label indicating the time and dosage. This will serve as the physician's order.

The State of Kansas also allows students to self-carry inhalers and Epipens **WITH** written doctor permission. It is important that students that self-carry understand how to administer their medication and the school policy associated with it. All inhalers and Epi-Pens, whether self-carried or kept in the health room, must have a current prescription label. It is requested that students with an inhaler or Epi-Pen have an "Emergency Action Plan" completed by their physician to have on file at school.

The health room does **NOT** stock cold or allergy medication. If your child will need over the counter medication during school, it will need to be in the original packaging with a form filled out by the parent for the nurse to administer during the school day.

Immunizations: Immunizations are required by the state of Kansas for school entry. The type and number are different depending on student grade level and periodically will change from year to year. If your child receives any vaccines after thy have begun school, please provide the school nurse with proof so that your child's health records can be updated. A student is allowed 60 days from enrollment to complete required immunizations provided they had had at least the first dose of each required vaccine. New students to the district and kindergarten students must show proof of immunizations before the first day of school. If proof of immunizations is not provided, the student will be excluded from school. Medical exemptions from immunizations will require a doctor's note annually. A Religious exemption must be signed by a parent or guardian, stating student is adherent to a religion which prohibits immunizations and is only required once.

Physical Exam: All students new to Kansas under the age of 9 must have a physical exam performed and a record on file with the nurse within 90 days of enrollment. Failure to provide documentation of a physical exam within 90 days, will result in exclusion from school.

Injury: Students with a cast, stitches, crutches, or serious injury should bring a note from the physician detailing the restrictions of school activities such as P.E. and recess. Students will also need a release from the physician to resume normal activities.

Food Allergies: Students who have severe food allergies should notify the school nurse prior to starting school to obtain the paperwork needed for the doctor to complete. A list of the restricted foods and an Emergency Action Plan for the student should be obtained from the doctor's office for the school. This information will be entered in to Skyward to alert the cashier if your child attempts to purchase something with that food in it.

Adequate Sleep and Breakfast: Without the necessary amount of sleep and nutrition, your student's ability to learn may be compromised due to stomachaches, headaches, and fatigue. Please make sure your child gets a good night's sleep and eats breakfast every morning.

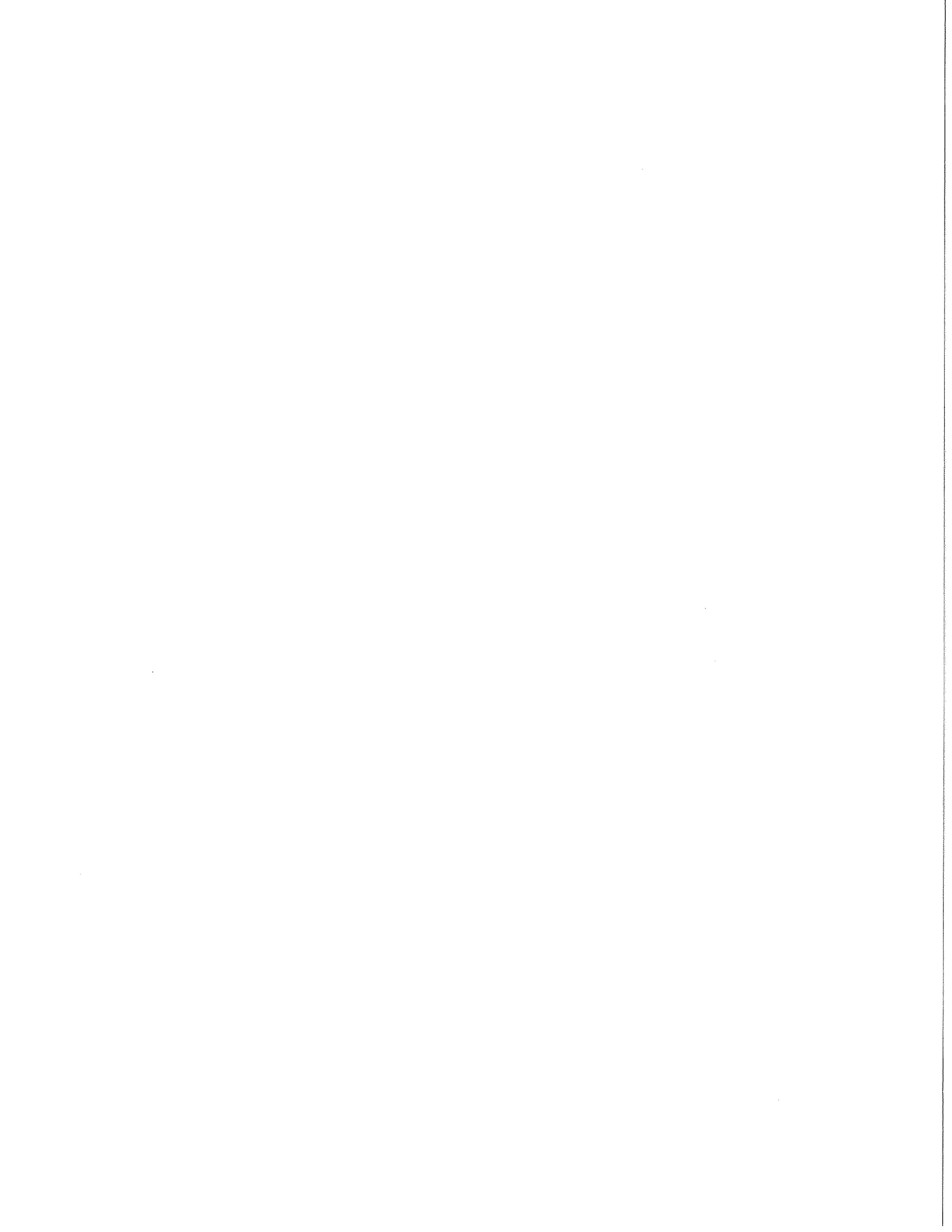
We hope that you and your child have a healthy, productive, and enjoyable school year! Please feel free to contact me with any questions or concerns. I am looking forward to meeting each of you come Fall!

Stacey M. Thein, RN
School Nurse
Prairie Elementary
913-993-4402
methein@smsd.org

Healthy Children.....Ready to Learn

Your School Nurse provides many health services for your child:

- Assessment and care of illness and injury
- Supervision and administration of medications
- Planning of care for special health needs
- Performing nursing procedures and treatments
- Assessment of hearing and vision
- Management of communicable diseases
- Health education as teacher and resource person
- Identification of health and safety hazards
- Implementation of immunization and health related laws
- Prevention and health promotion activities
- Referral to community resources



Forms to be completed by parent or guardian:

1. Health History and Permit form
2. Physical Exam Statement
   (age 8 & younger, new to Kansas schools)
3. Immunization Statement

SMSD
Health Services

Health History Form

Student's Name	Date of Birth / /	Age	Sex (M/F)	Grade

Mother/Guardian ______________	Father/Guardian ______________
Cell Phone: (____)____-______	Cell Phone: (____)____-______
Home Phone: (____)____-______	Home Phone: (____)____-______
Work Phone: (____)____-______	Work Phone: (____)____-______

Name of Physician ______________________ Phone (____)____-____

Name of last school attended ______________________ City/State ______________

Special Healthcare Planning/Serious Health Conditions

The school must be notified of a serious or life threatening health condition prior to the start of school as this may require an Individualized Health Plan.

☐ Allergy/Anaphylaxis: My child has severe allergy/anaphylaxis requiring an Epi Pen/Auvi-Q prescription.

Describe the allergy (food, insect, etc.) ______________________

☐ Asthma: ☐ Yes ☐ No My child uses rescue inhaler routinely for asthma symptoms

☐ Yes ☐ No My child has been hospitalized in the past year for asthma

☐ Yes ☐ No My child has needed steroids (prednisone) for asthma symptoms in the past year

☐ Diabetes: Date of diagnosis: __________ My student has: ☐ insulin pump ☐ insulin pen ☐ injected insulin

☐ Seizure Disorder: My student needs emergency medication for seizures. Name of medication: ______________

☐ Other: My child has special health care needs: wheel chair, tube feedings, breathing tube, catheter, intravenous tubes, other. Please describe your child's condition and healthcare needs: ______________________

Other Health Conditions

Check any condition your child currently has or has had in the past:

☐ ADD/ADHD ☐ Autism Spectrum	☐ Depression/Anxiety	☐ Orthopedic/Bone
☐ Allergies ☐ Seasonal	☐ Dental ☐ Braces/Orthodontia	☐ Serious Injury
☐ Dietary Restrictions	☐ Ear Infections ☐ Ear Tubes	☐ Surgery(s)
☐ Bladder/Bowel	☐ Hearing Impairment ☐ Hearing Aides	☐ Social/Emotional/Behavioral
☐ Blood Disorder	☐ Headaches/Migraines	☐ Stomach Aches
☐ Concussion	☐ Heart Disease	☐ Throat Infections
☐ Cancer	☐ Kidney Disease	☐ Vision: ☐Glasses ☐Contacts

Explain any health condition(s) checked ______________________

Medication your child is taking ______________________

Does your child require any restriction of physical activity in school? ☐ No ☐ Yes, specify nature and duration of restriction:

____

Emergency Contact (if parent/guardian cannot be reached)

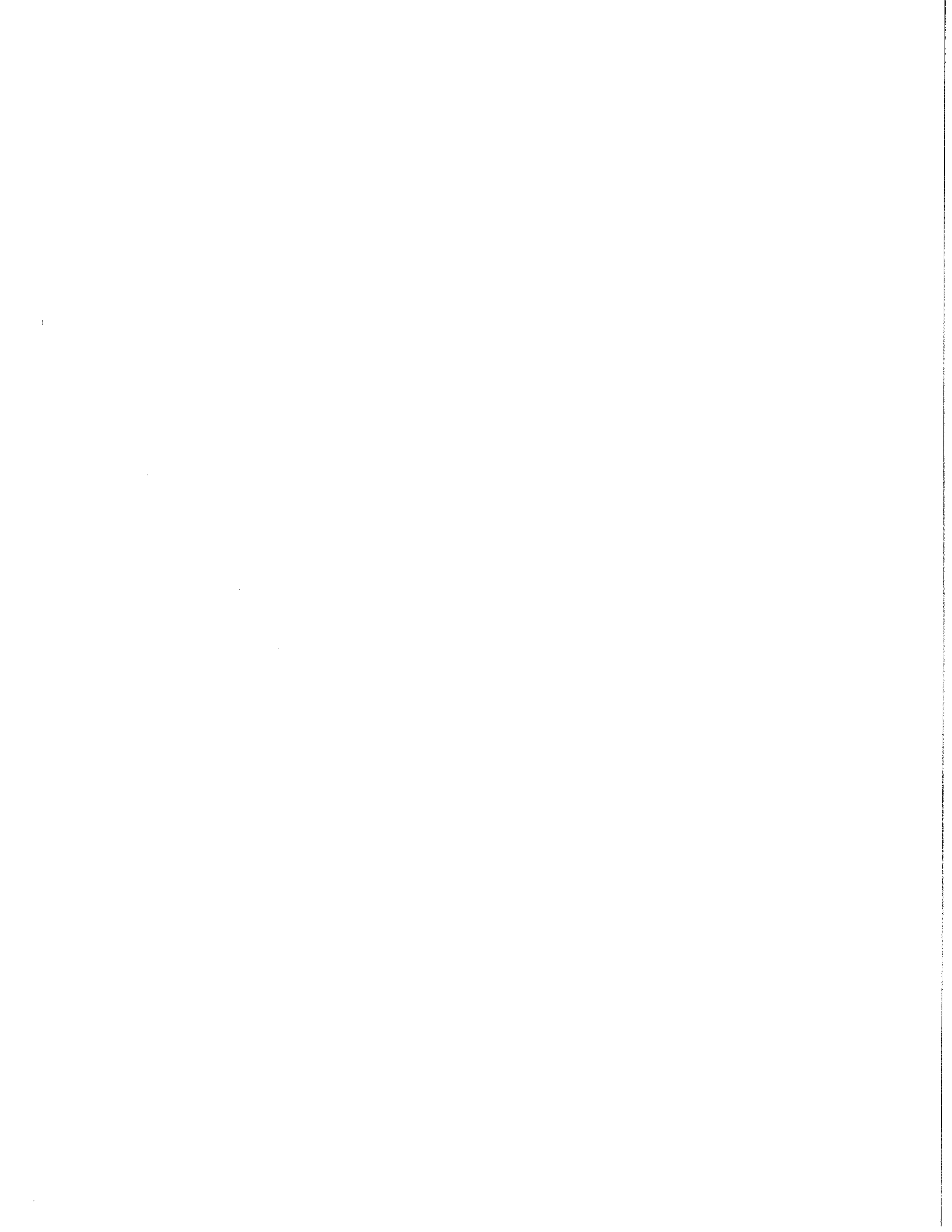
1. Name ______________ Relationship ______________ Phone (____)____-____

2. Name ______________ Relationship ______________ Phone (____)____-____

Preferred Hospital ______________________ City/State ______________

Statement of Consent *In order to better serve the healthcare needs of my child, I give my permission for the transfer of health information to the school and any other appropriate school or healthcare professionals including emergency personnel. This includes release of school immunization records to the KS Immunization Program, and the immunization registry for the purpose of assessment, reporting, and prevention of disease. I authorize school personnel to obtain emergency medical care for my student in the event I cannot be reached.*

Print Parent/Guardian Name	Signature of Parent/Guardian	Date
		/ /



Shawnee Mission School District

PHYSICAL EXAMINATION STATEMENT

Name of Student ______________________________

TO: Principal/Nurse of Prairie Elementary

I, the parent/guardian of __________________________, am affirming that I understand that the Kansas statute states that the above named student is required to have a physical examination within ninety (90) days after school enrollment or show proof that one has been conducted within 12 months prior to enrollment.

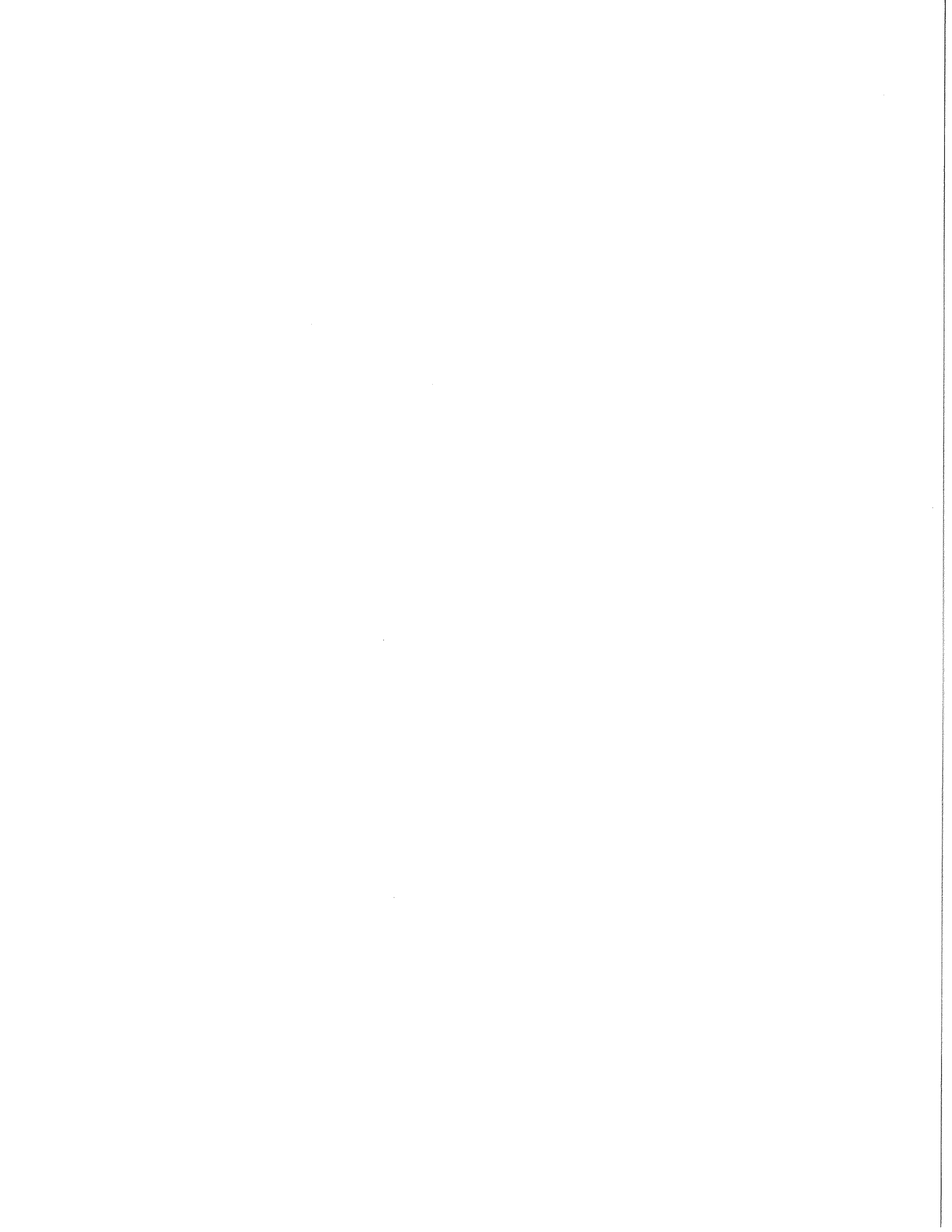
I further understand that if the results of a physical examination are not forwarded to the school nurse or principal by the date noted below, the student will be excluded from school.

Parent/Guardian Signature ______________________________________

Date Signed ____

Date of School Entry _____

Deadline Date First Day of School, August 12th, 2016.



IMMUNIZATION STATEMENT

Name of Student ______________________________

TO: Principal/Nurse of Prairie Elementary.

I, the parent/guardian of______________________________, state that all tests and/or inoculations required by Kansas School Immunization Laws 72-5208, 72-5209, as amended in 1994, are in the process of being received. Records indicating completion of all required immunizations (including diphtheria, tetanus, pertussis, rubella, rubeola, mumps, polio, hepatitis B, varicella) will be in the school nurse's office within sixty (60) days after enrollment to school.

All students enrolling in the Shawnee Mission School District for the first time, must show written proof that they have received at least one dose of each of the immunizations required by the state of Kansas before they may attend any classes.

I further understand that if I have not presented the completed immunization form as required by law by the date noted below, the student will be excluded from school until proof of required immunizations is provided.

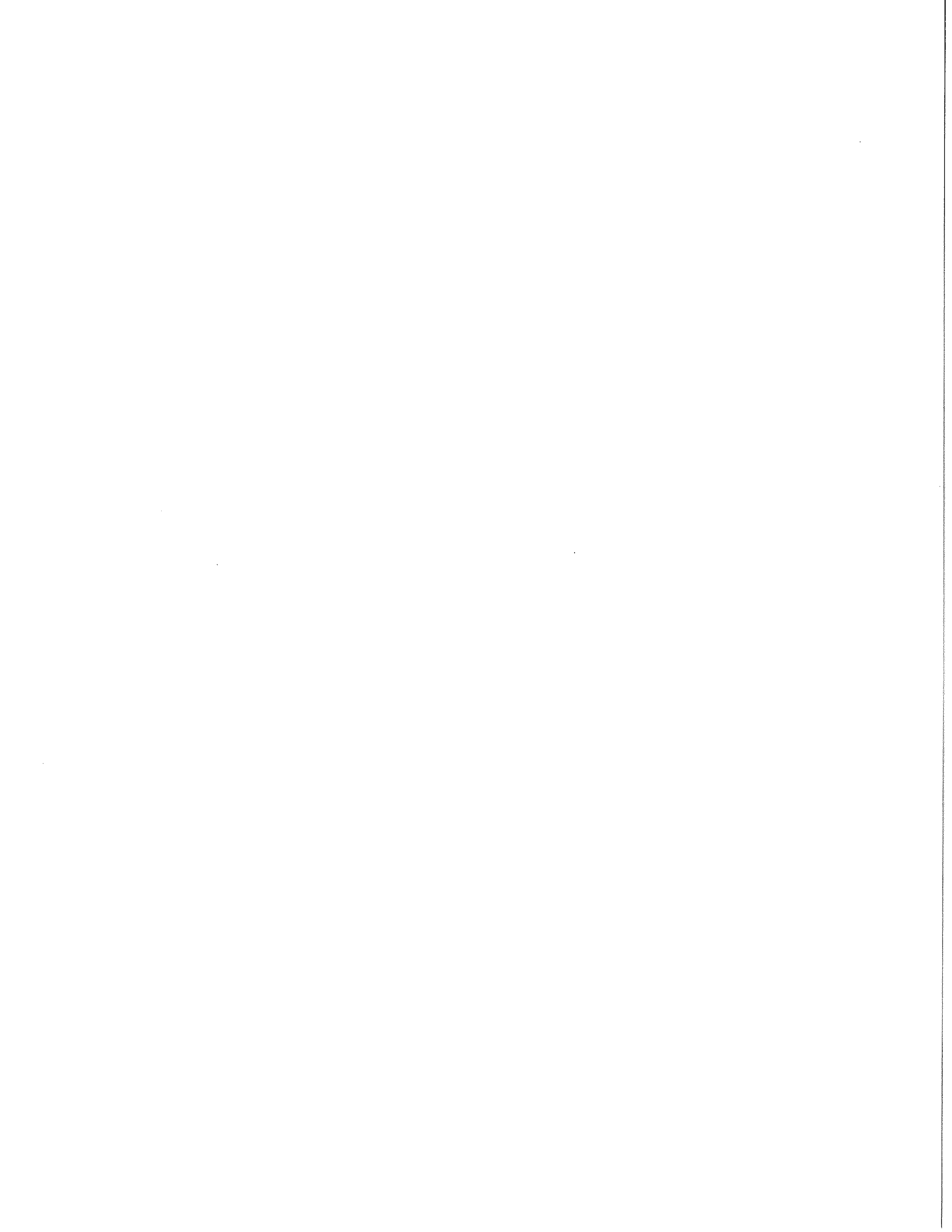
Parent/Guardian Signature ______________________________

Date Signed ______________________________

Date enrolled in school ______________________________

Date immunization record is due First Day of School - Aug. 12th, 2016

Revised 9/07



Health Services
Shawnee Mission School District

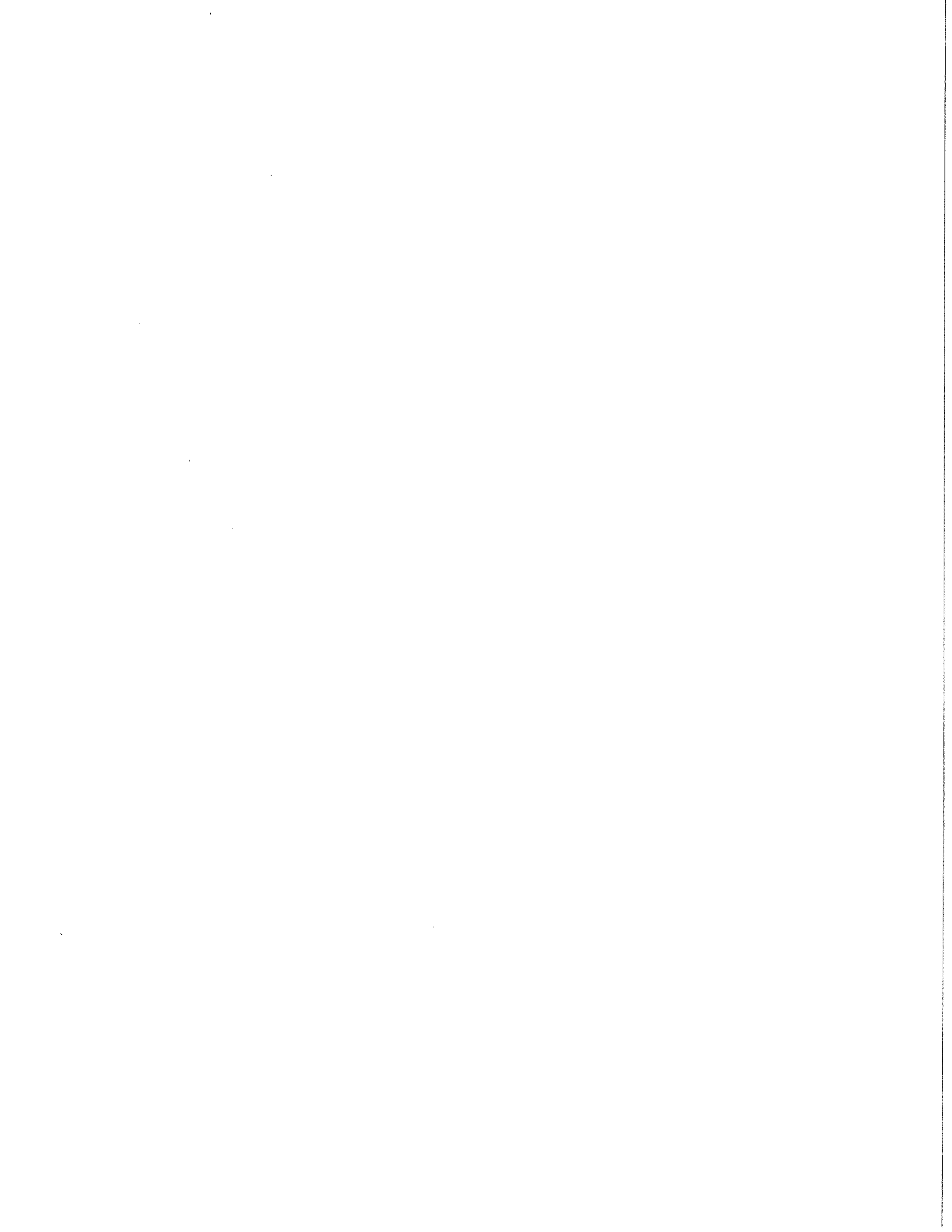
Medication Administration Guidelines

Permission: Written permission from the parent or guardian must be on file for all medications given at school, including over-the-counter (OTC) medications. Authorization must be renewed every school year.

Medication: Only FDA approved prescription and OTC medications are allowed to be administered by school personnel. OTC medications will be given per package label dosing instructions, unless prescribed by a physician.

Container: Prescription medication brought to school must be in the original container with a current prescription label on the bottle including the child's name, doctor's name, date, medication name, dosage, and time to be given. Controlled substances must be submitted with a Medication Count Form. OTC medications provided by parent must be in the original container and labeled with the student's name.

Revised 8/18/2015



Health Services
Shawnee Mission School District

Medication Permission Form

Student Name: D.O.B.: Grade: School Yr:

Over-The-Counter Medication

By initialing below, I give permission for school personnel to administer the following medication(s) as needed to my student for minor discomfort or injury. Medications supplied by school may vary between buildings and grade levels.

______ Acetaminophen (Tylenol)
______ Ibuprofen (Advil or Motrin)
______ Cough drop (non-medicated)
______ Eye drop (non-medicated lubricating)
______ Topical medication (antibiotic ointment, calamine lotion, hydrocortisone cream)
______ Antihistamine oral (diphenhydramine, cetirizine)
______ Antihistamine allergy eye drops
______ Antacid (Tums)

Parents may also supply other over-the-counter medications. Please list below:

Medication name: ____________________ Dosage: ________
Reason given: ____________________ Time: ________

Medication name: ____________________ Dosage: ________
Reason given: ____________________ Time: ________

Prescription Medication

Medication name: ____________________ Dosage: ________
Reason given: ____________________ Time: ________

Medication name: ____________________ Dosage: ________
Reason given: ____________________ Time: ________

On early dismissal or late start days please indicate one of the following:

_____Do NOT administer medication on early dismissal days
_____Do NOT administer medication on late start days
_____Administer medication at adjusted lunch time
_____Administer medication at prescribed time

To ensure continuity of care, I give permission for the school nurse to communicate with my student's healthcare provider regarding medication administration at school.

Physician Name: Phone number

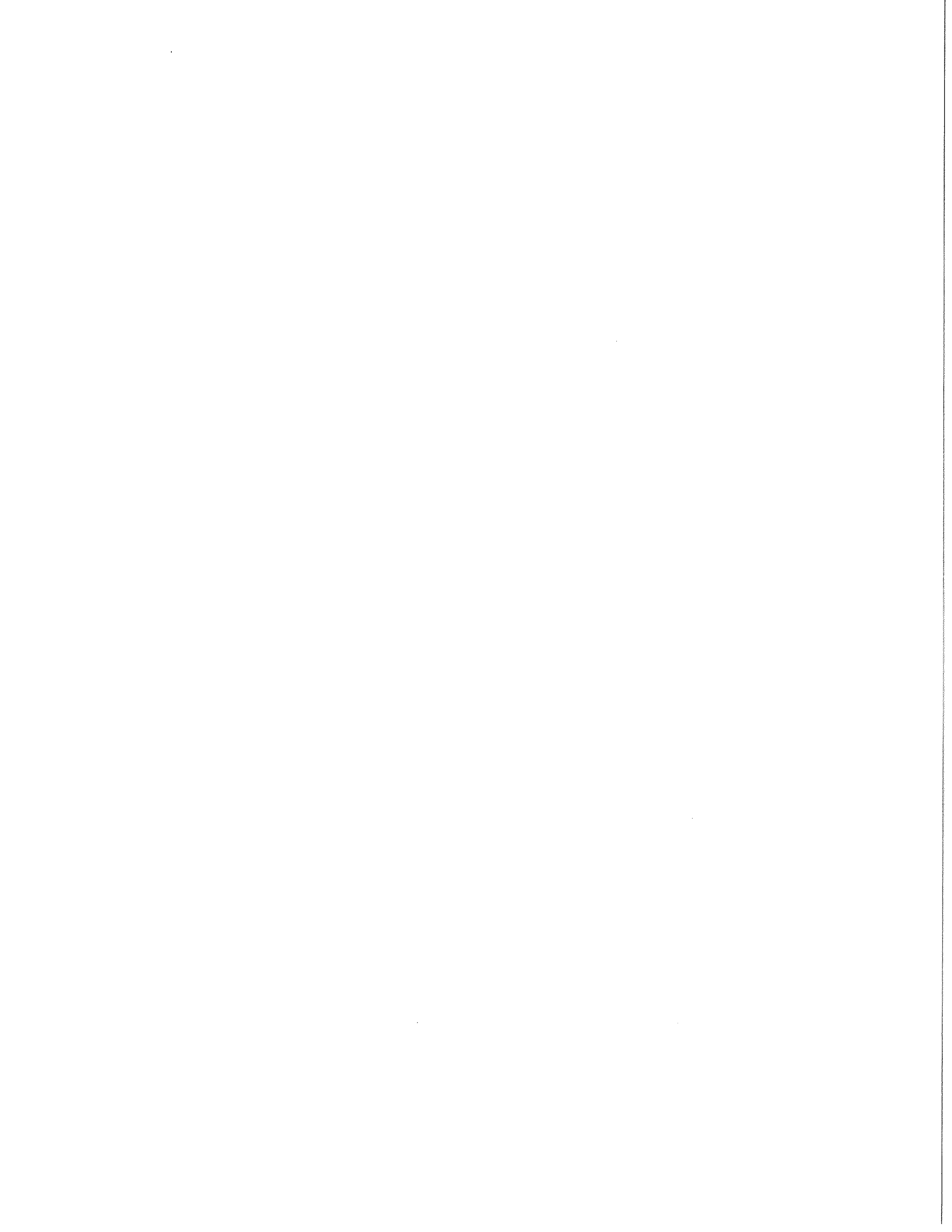
Physician Signature (required if no Rx label): Date

School personnel who administer medication according to proper dosing instructions shall be held harmless for any adverse reaction experienced by the student. My student has previously taken the medications(s) listed above with no known adverse reaction.

Parent/guardian Name:

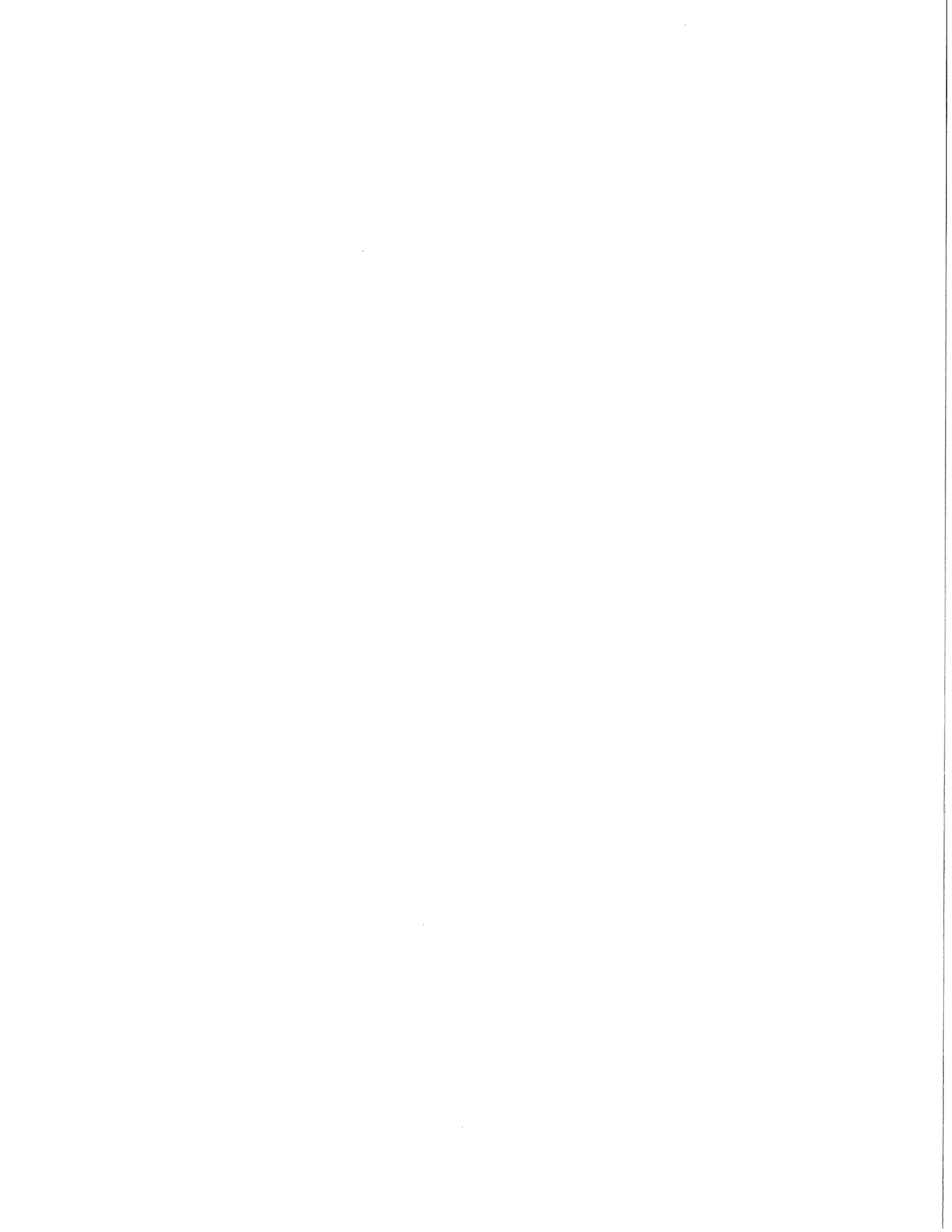
Parent/guardian Signature: Date

Revised 8/18/2015



Forms to be completed by your healthcare professionals:

1. Kansas Certificate of Immunization
   (copy of immunization card or office record ok)
2. Physical Examination Record
   (age 8 & younger, new to Kansas)



KANSAS CERTIFICATE OF IMMUNIZATIONS (KCI)

This record is part of the student's permanent record and shall be transferred from one school to another as defined in Section 72-5209 (d) of the Kansas School Immunization Law (amended 1994.)

Student Name: ______________________ Address: ______________________

Parent or Guardian Name: ______________________

Phone: ____________

Birthdate (MM/DD/YYYY): ____________ SEX: [ ] MALE [ ] FEMALE Race: ____________ Ethnicity: ____________ County: ____________

VACCINE	RECORD THE MONTH, DAY, AND YEAR THAT EACH DOSE OF VACCINE WAS RECEIVED ⊘ = Dose determined invalid by provider · = Invalid Dose. KSWebIZ minimum age/interval not met.						
	1st	2nd	3rd	4th	5th	6th	7th
DTaP/DT/Td/Tdap (Diphtheria, Tetanus, Pertussis) Required for school entry. Single Tdap required for grades 7-12. State Type							
Polio Required for school entry.						If additional doses are added, please initial the dose and sign below:	
HEP B (Hepatitis B) Required for school entry.							
Varicella (Chickenpox) Required for school entry.			Hx of Disease: NO Physician Signature:		Date of Illness: ______		
MMR (Measles, Mumps, and Rubella combined) Required for school entry.							
Influenza (Flu) Recommended annually for ages 6mo and older. Not required for school entry.							
HIB (Haemophilus Influenzae Type B) Required < 5 years of age for preschool or child care operated by a school.							
PCV (Pneumococcal Conjugate) Required < 5 years of age for preschool or child care operated by a school.							
HEP A (Hepatitis A) Required < 5 years of age for preschool or child care operated by a school.							
MCV4 (Meningococcal) Initial dose recommended at 11-12 years of age and booster dose recommended after 16 years of age. Not required for school entry.							
HPV (Human Papillomavirus) Recommended for males and females at 11-12 years of age. Not required for school entry.							
Rotavirus Recommended < 8 mo. Not required for school entry.							

DOCUMENTATION

KCI MAY ONLY BE SIGNED BY A PHYSICIAN (MD/DO), HEALTH DEPT, OR SCHOOL.

☐ I certify I reviewed this student's vaccination record and transcribed it accurately

Agency Name:

Authorized Representative:

Address:

The record presented was: Date ______

☐ Kansas Immunization Record

☐ Other Immunization Record (Specify) ______________

LEGAL ALTERNATIVES TO VACCINATION REQUIREMENTS "KSA 72-5209"

1. "Annual written statement signed by a licensed physician (Medical Doctor/M.D. or Doctor of Osteopathy/D.O.) stating the physical condition of the child to be such that the tests or inoculations would seriously endanger the life or health of the child." Medical exemption shall be validated annually by physician completion of KCI Form B and attachment to the KCI.

2. "Written statement signed by one parent or guardian that the child is an adherent of a religious denomination whose religious teachings are opposed to such tests or inoculations."

KANSAS IMMUNIZATION PROGRAM
1000 SW Jackson, Suite 210, Topeka, KS 66612-1274
PHONE 785-296-5591 FAX 785-296-6510

I give my consent for information contained on this form to be released to the Kansas Immunization Program for the purpose of assessment and reporting.

______________________ Parent/Legal Guardian's Signature ____________ Date

Rev. 1/2016

KANSAS IMMUNIZATION REQUIREMENTS: Based on age of child as of September 1 of current school year.

As per Kansas Statute 72-5209, all children upon entry to school must be appropriately vaccinated. In each column below, vaccines are required for all ages listed in that column.

Pre-Kindergarten Ages 0-4 ACIP Recommended Schedule

Age	Vaccines
Birth	HEP B
2 Months	DTaP/DT POLIO HEP B PCV ROTAVIRUS
4 Months	DTaP/DT POLIO HIB PCV ROTAVIRUS
6 Months	DTaP/DT POLIO HEP B HIB PCV ROTAVIRUS
12-15 Months	MMR VAR HIB PCV
12-23 Months	HEP A
15-18 Months	DTaP/DT
6 Months after 1st dose	HEP A

ACIP Recommended Schedule http://www.cdc.gov/vaccines/schedules/

Kindergarten through 12th Grade

DTaP: 5 Doses

a) 4 week minimum interval between first 3 doses; 6 month interval between dose 3 and dose 4
b) 4 doses acceptable if dose 4 given on or after the 4th birthday
c) If dose 4 administered before 4th birthday, 5th dose must be given at 4-6 years of age

Tdap/Td: 7 years and older

3 doses if no history of any DTaP doses (a-b)

a) 4 week minimum interval between dose 1 (Tdap) and dose 2 (Td); first dose must be Tdap
b) 6 months between dose 2 (Td) and 3 (Td)
c) Single dose of Tdap for an incomplete primary DTaP series or;
d) Single dose of Tdap required for Grades 7-12

Polio: Grades K - 5, new students and students completing the polio series

__All IPV or OPV Schedule__

a) 4 week minimum interval between first 3 doses; 6 months interval between dose 3 and dose 4; one dose after 4th birthday
b) 3 doses acceptable, if 4 weeks between dose 1 and 2; 6 months between dose 2 and 3; one dose after 4th birthday

__Combination IPV/OPV - 4 doses required__

a) 4 week minimum interval between first 3 doses; 6 months interval between dose 3 and dose 4; one dose after 4th birthday
b) 3 doses not acceptable with combination schedule

Polio: Grades 6 - 12th

__All IPV or OPV Schedule__

a) 4 doses-4 weeks minimum interval betwen doses regardless of age given
b) 3 doses acceptable -4 weeks minimum interval between dose 1 and dose 2; dose 3 after 4th birthday

__Combination IPV/OPV - 4 Doses required__

a) 4 weeks minimum interval regardless of age given

New students and students completing series must have 6 months between last two doses with one dose after 4th birthday

MMR: 2 doses Grades K - 12th

a) First dose on or after the 1st birthday
b) 28 days minimum interval between doses

Varicella: 2 doses Grades K - 12th

a) First dose on or after the 1st Birthday
b) Second dose must be given at least 28 days after first dose
c) No doses required if prior varicella disease verified by a physician

Varicella-ACIP minimum interval for less than 13 yrs is 3 months; 13 yrs and older is 4 weeks however, a 28 day interval regardless of age is valid.

Hepatitis B: 3 doses Grades K - 12th

a) 4 week minimum interval between dose 1 and dose 2
b) 8 week minimum interval between dose 2 and dose 3
c) 16 week minimum interval between dose 1 and dose 3
d) Dose 3 must be given after 24 weeks of age

Additional Notes:

- Vaccine doses given up to 4 days before the minimum interval or age may be considered valid.
- With the exception of Hepatitis B vaccine, immunizations given before 6 weeks of age are not considered valid.
- Half doses or reduced doses of vaccine are not considered valid.

PARENTS AND/OR GUARDIANS ARE NOT AUTHORIZED TO COMPLETE KCI FORMS.

KCI FORM B - MEDICAL EXEMPTION is located at http://www.kdheks.gov/immunize/imm_manual_pdf/KCI_formB.pdf
BLANK VERSION OF KCI FORM is available at http://www.kdheks.gov/immunize/download/KCI_Form.pdf

A ROSTER WITH THE NAMES OF ALL EXEMPT STUDENTS SHOULD BE MAINTAINED. PARENTS OR GUARDIANS OF EXEMPT CHILDREN SHOULD BE INFORMED THAT THEIR CHILDREN SHALL BE EXCLUDED FROM SCHOOL IN THE EVENT OF AN OUTBREAK OR SUSPECTED CASE OF A VACCINE-PREVENTABLE DISEASE.

Physical Exam Record

To be completed by certified healthcare professional

Student's Name	Date of Birth	Age	Sex (M/F)	Grade
	/ /			

Does the child have a diagnosed medical condition? ☐ No ☐ Yes
Specify:

Does the child have a health condition that may require EMERGENCY ACTION while at school? ☐ No ☐ Yes
(e.g.: seizure, severe allergic reaction, diabetes)
Specify:

Is the child on prescription medication? ☐ No ☐ Yes
Specify medication and diagnosis:

Are any immunization, booster, or revaccinations indicated? ☐ No ☐ Yes
Specify type and due date:

Does the child have history of chicken pox disease? ☐ No ☐ Yes
Specify date:

Does the child require any restriction of physical activity in school? ☐ No ☐ Yes
Specify nature and duration of restriction:

EXAM FINDINGS/CONCERNS

Physical Exam	WNL	ABNL	Area of Concern	Health Area Of Concern	Yes	No	Referred for Evaluation
Head				Developmental			
Eyes				Mobility			
ENT				Speech/language			
Neuro				Hearing			
Dental				History of frequent ear infections			
Respiratory				Vision			
Cardiac				Nutrition			
GI/GU				History of traumatic head injury			
Abdomen				Signs of acanthosis nigricans			
Endocrine				Learning disability			
Skin				Attention deficit hyperactivity disorder (ADHD)			
Genital				Psychosocial			
Orthopedic				Other:			

Please explain any abnormal or area of concern findings:

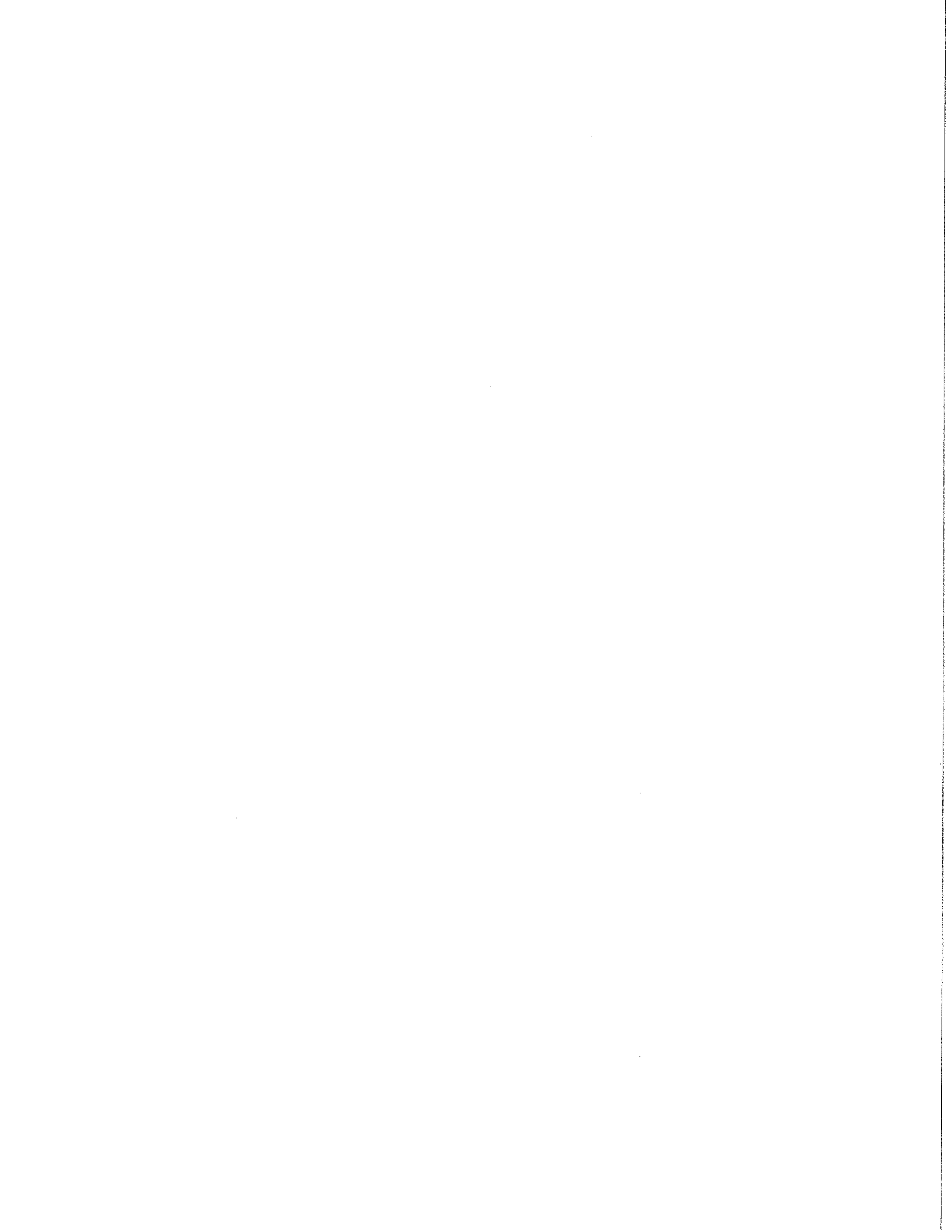
SCREENING RESULTS

Height: ft. in.	Weight: lbs.	Body Mass Index (BMI):
Blood Pressure:		Vision: L 20/ R 20/ Both 20/ Glasses ☐ Contacts ☐

Print Name	**Signature of Healthcare Provider**	**Date**
		/ /

State law (K.S.A. 72-5214) requires all children up to the age of nine entering a Kansas public school for the first time present results of a health assessment prior to school entry.

Revised 3/2015



Parents, please take this form to your child's next dental appointment. We encourage you to seek dental care for your child at least once a year. Thank you for your concern.

School Dental Health Form

Student Section:

Student's Name: ______________________________ Age: ____ Grade: ___________

School: ____________________________________ City: _____________________

To students and parents: The purpose of requesting each student to have his/her teeth examined by the dentist at least once each year, or more often if the dentist so advises, is to discover dental defects and infection, if present, in the beginning. By doing this, treatment can be given with the least amount of discomfort to the student and at the lowest cost to the parent. Pain, sickness, and unnecessary loss of teeth resulting from dental diseases are thereby also prevented. You are therefore urged to take this form to your family dentist and have any necessary dental work done as soon as possible. When the dentist has signed the form, please return it to the school..

Date: ____________________ Teacher or School Nurse: ______________________________

Dentist Section:

A. I have examined the teeth of the above student and find no fillings, extractions, or cleaning needed..

B. I have completed the necessary dental work for this student.

Date: ____________________ DDS ____

42-16017