Kindergarten Orientation-

Health Care Needs and State Requirements

IMMUNIZATIONS

- STATE LAW REQUIRES CERTAIN IMMUNIZATIONS TO BE ABLE TO ENTER INTO PUBLIC SCHOOL
- YOU NEED TO BRING A COPY OF YOUR CHILD'S IMMUNIZATION RECORD TO THE OFFICE
- IF YOU NEED FINANCIAL ASSISTANCE THERE ARE RESOURCES AVAILABLE

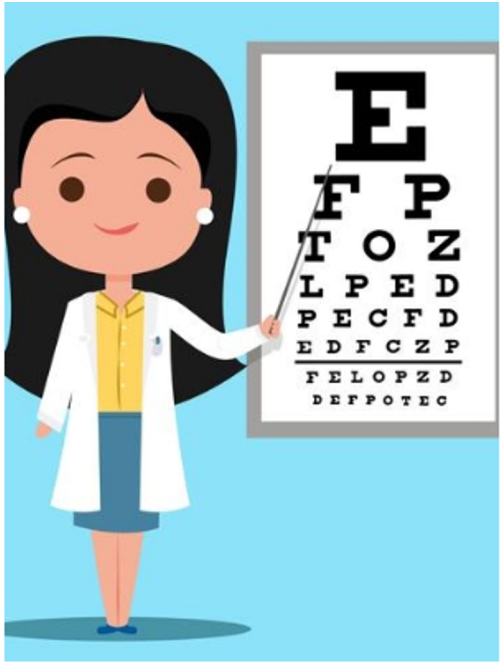
THE OFFICE HAS LOTS OF ANSWERS- PLEASE ASK YOUR QUESTIONS

WAIVERS

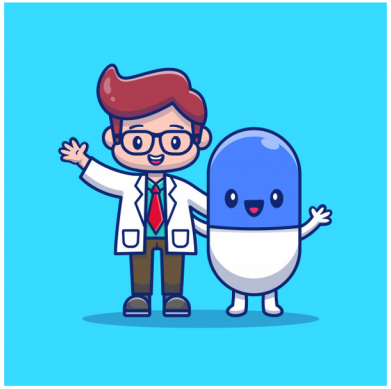
- IF YOU ARE UNABLE TO IMMUNIZE YOUR CHILD OR IF YOU CHOOSE NOT TO IMMUNIZE YOUR CHILD YOU MUST GET AN EXEMPTION
- THE HEALTH DEPARTMENT HAS AN ONLINE MODULE TO COMPLETE
- IF THERE IS AN OUTBREAK OF COMMUNICABLE DISEASE IN THE SCHOOL...

VISION SCREENING

- GOOD VISION IS IMPORTANT FOR LEARNING
- ASK FOR A VISION SCREEN AT THEIR NEXT WELL CHILD EXAM
- WE DO SCREENINGS IN THE FALL
- FINANCIAL ASSISTANCE IS AVAILABLE FOR THOSE THAT NEED IT



MEDICATIONS AT SCHOOL



- IF YOUR CHILD NEEDS TO TAKE MEDICATIONS WHILE AT SCHOOL- WE CAN HELP WITH THAT
- WE NEED THE PROPER FORMS IN ORDER TO DO SO
- MEDICATIONS ARE KEPT IN THE OFFICE
- EXCEPT YOUR CHILD MAY CARRY THEIR OWN- INHALERS, EPI-PENS, AND DIABETIC MEDICATION (INSULIN AND GLUCAGON)- IF YOUR DOCTOR SIGNS THE FORM THAT THEY ARE ABLE TO
- ALL MEDICATION MUST BE CHECKED IN AT THE OFFICE BY AN ADULT
- PLEASE MAKE SURE TO HAVE THE ORIGINAL PACKAGING, PHARMACY LABEL, AND THAT IT IS NOT EXPIRED

JORDAN SCHOOL DISTRICT NURSING SERVICES
SCHOOL MEDICATION AUTHORIZATION FORM

School Year: _____

Student's Name: _____ **Birth Date:** _____

School: _____ **Grade:** _____ **Teacher:** _____

TO BE COMPLETED BY HEALTHCARE PROVIDER:
This order can only be signed by Physician (MD, DO), Dentist, Nurse Practitioner (NP, FNP, PNP, APRN/PP), or Certified Physician's Assistant. **Utah Law (53a-11-501) requires that medication administered during school hours must be medically necessary.**

*** ONLY ONE MEDICATION PER FORM ***

Diagnosis: _____

Medication: _____ **Duration To Be Given:** _____

Dosage: _____ **Time:** _____ **Route:** _____

Reportable Adverse Reactions/Side Effects: _____

_____

Special Instructions: _____

MEDICATION SELF-ADMINISTRATION AUTHORIZATION
*According to Utah State Law Students are **only** allowed to carry and self-administer epinephrine auto injectors, asthma inhalers and insulin. The above named student is under my care and has been trained in self-administration of the following medication, and is capable of carrying and self-administering the indicated medication:*
[ ] Auto-Injectable Epinephrine [ ] Inhaler [ ] Insulin

Name of Healthcare Provider: _____ **Phone:** _____

Healthcare Provider Signature: _____ **Date:** _____

PARENTAL RESPONSIBILITIES:
- Parent must furnish the school with a completed *School Medication Authorization Form* prior to any medications being administered by school personnel.
- The medication must be delivered to the school by the parent in the original container, labeled with the child's name, medication, time, dosage, and healthcare provider's name.
- All medication must be delivered to the school by an adult and picked up by an adult within two (2) weeks of last dose given.
- If there is a change in the medication or medication dosage, a new *School Medication Authorization Form* must be completed before school personnel can administer the new medication or new medication dose.

I UNDERSTAND THAT BY SIGNING THIS FORM:
- I am giving permission to the school personnel to contact the healthcare provider regarding this medication.
- I am giving permission for this medication to be administered by someone other than a licensed nurse who has been appointed by the school administrator.
- *(Except in the case of glucagon or auto-injectable epinephrine),* school personnel CANNOT administer:
  - the 1st dose of a new medication, OR
  - the 1st dose of a *dosage change* of any medication.

Parent Signature: _____ **Date:** _____ **Emergency Phone Number:** _____

District Nurses Signature: _____

White – School Copy Yellow – District Nurse Copy Pink - Parent Copy Revised 9/2008

SCHOOL MEDICATION AUTHORIZATION FORM

THIS FORM CAN BE FOUND ON THE "NURSING SERVICES" PAGE OF THE JORDAN SCHOOL DISTRICT WEBSITE UNDER "MEDICATION GUIDELINES"

OR

YOU MAY PICK ONE UP IN THE OFFICE

CARE PLANS

- PLEASE LET THE OFFICE KNOW RIGHT AWAY IF YOUR CHILD HAS ANY MEDICAL NEEDS
- WE WANT TO MAKE CERTAIN YOUR CHILD HAS WHAT THEY NEED IN ORDER TO SUCCEED
- THEY MAY NEED A HEALTH CARE PLAN
- PLEASE SIGN THE REQUEST FOR HEALTH SERVICES FORM
- WE TRAIN OUR STAFF TO RESPOND TO MEDICAL NEEDS

JORDAN SCHOOL DISTRICT NURSING SERVICES
REQUEST FOR SPECIAL HEALTH CARE SERVICES
AND RELEASE OF CONFIDENTIAL INFORMATION

Student Name _____ Date of Birth _____ Parent or Legal Guardian Name _____

Address _____ City, State, Zip _____

Phone (home/mobile) _____ Email _____

School _____ Teacher _____ Grade _____

☐ **Request for NEW Health Care Plan** ☐ **Update/Re-evaluation of Current Health Care Plan**

Please describe the student's medically diagnosed condition and the service and/or treatment you are requesting to be administered by school personnel. Requested services must be medical necessary during school hours.

Specific information to be released:
_____ Two-way Communication _____ Progress Notes _____ Discharge Summary _____ Other_____

I authorize the release of the above named student's health information (as designated below)

From (Physician): _____ To: Jordan School District Nursing Services/Agency Nursing Services
Phone: _____

- I hereby indicate that I am the parent or legal guardian of the above named student and that I am requesting that Jordan District personnel administer the health care services described above.
- I understand that someone other than a licensed nurse, in accordance with the Utah Nurse Practice Act, may administer health care services.
- I further understand that health care services will not be provided by Jordan School District personnel prior to the submission of a primary health care provider's statement, if requested, and the development of a Health Care Plan by a Jordan School District nurse in conjunction with communication with the licensed health care provider, as needed. I may be required to supply additional information or forms.
- I understand that the health care provider is not responsible for any further disclosures of the released information by the school/district. I also understand that the released medical records may become part of the student's educational records and may be forwarded to another school in which the student seeks or intends to enroll. The school and district will protect this information in compliance with the Family Educational Rights and Privacy Act (FERPA).
- Signing this release is voluntary. Refusing to sign it will not affect the school or district's commitment to provide a quality education for the student. However, the requested records and permission to communicate with the student's licensed health care provider may be required in order for the school to implement an appropriate plan of education, learning accommodations, and educational modifications. Additionally, permission to communicate with the student's licensed health care provider will be required in order to enable school nurses to provide health care services.
- I understand that if I authorize release of the above information to any individual or entity that is not legally required to keep it confidential, the information may no longer be protected by the Health Insurance Portability and Accountability Act of 1996, or any other state of federal law.
- I understand that I have a right to receive a copy of this form after signing and I may inspect the information that is disclosed. By my signature below, I authorize the release and use of the information in accordance with the rights, restrictions and understandings above.
- This authorization shall remain in effect for twelve (12) months from the date of signing. I understand that I have the right to revoke this authorization to the school and student's physician on behalf of my minor child by providing written notice to the health care provider consistent with the health care provider's policies. Revocation does not affect release of medical records made prior to the revocation.
- By my signature below, I authorize the release and use of the information in accordance with the rights, restrictions and understandings above.

_____ _____
Parent or Legal Guardian's Signature **Date**

_____ _____
Witness (If required) **Date** **Witness (If required)** **Date**

Copy to Parent _____**(initial)**

REQUEST FOR SPECIAL HEALTH CARE SERVICES FORM

YOU CAN FIND THIS FORM ON THE "NURSING SERVICES" PAGE OF THE JORDAN SCHOOL DISTRICT WEBSITE UNDER "RESOURCES FOR PARENTS"

OR

YOU MAY PICK ONE UP IN THE OFFICE

STAY HOME WHEN SICK

IF YOUR CHILD IS NOT FEELING WELL- PLEASE KEEP THEM HOME

Rachel Danielson, RN BSN
(385) 256-6199
rachel.danielson@jordandistrict.org

SCHOOL MEDICATION AUTHORIZATION FORM

https://nursingservices.jordandistrict.org/wp-content/uploads/sites/23/Medication-MD-Form_ADA.pdf

REQUEST FOR SPECIAL HEALTH CARE SERVICES FORM

https://nursingservices.jordandistrict.org/wp-content/uploads/sites/23/JORDAN-SCHOOL-DISTRICT-NURSING-SERVICES-REQUEST-FOR-SPECIAL-HEALTH-CARE-SERVICES-AND-RELEASE-OF-CONFIDENTIAL-INFORMATION.pdf