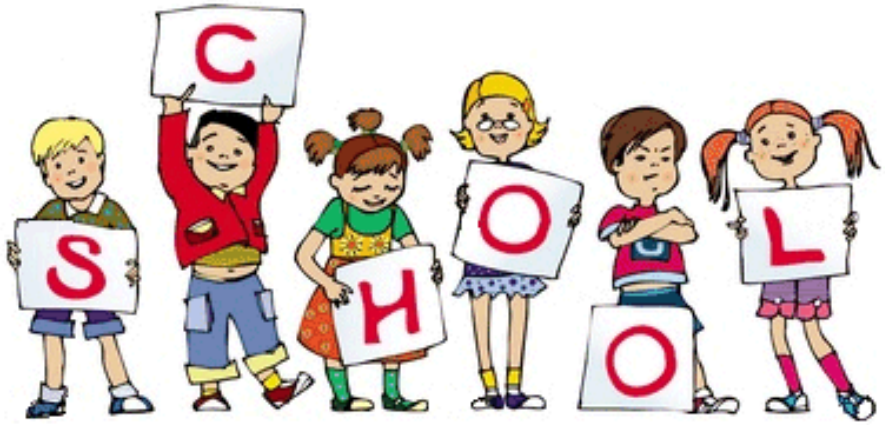

School Health

Guilford County Schools

The School Health Program supports Guilford County Schools through case management, health education and consultation in order to remove health related barriers to learning.

The American Academy of Pediatrics has a new policy statement published in the June 2016 issue of Pediatrics that calls for a minimum of one full-time registered nurse in every school.

School Year 2015-2016

GCS Student Population – 73,070

33 Nurses Served 125 Schools

1 Nurse : 2,214 Students

School Nurse Contacts -133,548

School Visits – 3,886

School nurses act as agents of the school and must follow all school policies and procedures.

For example: Lice Policy, Medication Policy

The School Health Program Provides:

- Chronic Disease Management
- Training of school staff and monitoring of medical procedures
- Medication administration training and monitoring
- Immunization and Health Assessment follow-up
- Screening, referrals, and follow-up for: vision, dental, and other health conditions

PUBLIC SCHOOLS OF NORTH CAROLINA
State Board of Education | Department of Public Instruction

January 2016

NORTH CAROLINA HEALTH ASSESSMENT TRANSMITTAL FORM

This form and the information on this form will be maintained on file in the school attended by the student named herein and is confidential and not a public record.
(Approved by North Carolina Department of Public Instruction and Department of Health and Human Services)

PARENT to COMPLETE THIS SECTION

Student Name: ☐ M ☐ F
(Last) (First) (Middle)

Birthdate (M/D/YYYY): **School Name:**

Hispanic of Latino Origin: ☐ 1 Yes ☐ 2 No

Race: ☐ 1 Other Non-White ☐ 2 White ☐ 3 Black ☐ 4 American Indian ☐ 5 Chinese ☐ 6 Japanese ☐ 7 Hawaiian ☐ 8 Filipino ☐ 9 Other Asian ☐ 10 Unknown

Home Address: **City:** **State:** **County:**

Parent Information: Name of Parent, Guardian, or person standing in loco parentis:

Telephone(s)
Home:
Work:
Cell Phone:

Health Concerns to be shared with authorized persons (school administrators, teachers, and other school personnel who require such information to perform their assigned duties):

HEALTH CARE PROVIDER TO COMPLETE THIS SECTION

Medications prescribed for student:

Student's allergies, type, and response required:

Special diet instructions:

Health-related recommendations to enhance the student's school performance:

Vision screening information:
Passed vision screening: ☐ Yes ☐ No
Concerns related to student's vision:

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January 2016

Hearing screening information:
Passed hearing screening: ☐ Yes ☐ No
Concerns related to student's hearing:

Recommendations, concerns, or needs related to student's health and required school follow-up:

School follow-up needed: ☐ Yes ☐ No

Medical Provider Comments:

Please attach other applicable school health forms:

Immunization record attached: ☐
School medication authorization form attached: ☐
Diabetes care plan attached: ☐
Asthma action plan attached: ☐
Health care plans for other conditions attached: ☐

Health Care Professional's Certification
I certify that I performed, on the student named above, a health assessment in accordance with G.S. 130A-440(b) that included a medical history and physical examination with screening for vision and hearing, and if appropriate, testing for anemia and tuberculosis. I certify that the information on this form is accurate and complete to the best of my knowledge.

Name: Title:

Signature: _____ Date (m/d/yyyy):

Practice/Clinic Name:			Practice/Clinic Address:	
Practice/Clinic City:	State:	Zip:	Phone:	Fax:

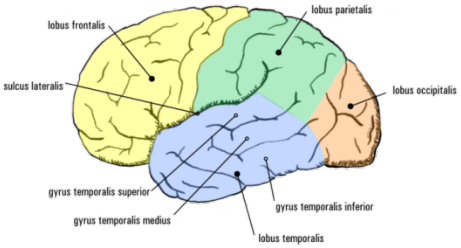
Provider Stamp Here:

School Health Offers Many Other Services

- Case Management of Chronic Conditions
- Health Care Plans
- Health Education Classes
- Pregnancy Referral/Follow-up/Counseling
- Liaison between Homes, Schools, and Community Health Care Providers

4 Most Common Chronic Diseases in the School Setting

- Asthma
- Severe Allergies
- Seizures
- Diabetes



10% of GCS Students Identified with a Chronic Health Condition in 2015-2016

- Asthma - 4,305 students
- Severe Allergies – 2,087 students
- Seizure Disorder – 334 students
- Type I Diabetes – 208 students

Chronic Disease Case Management Goals Include:

- Reduced Symptoms
- Improved Academic Success
- Improved Self Care
- Increased Teacher/Staff Education
- Safer School Environment
- Improved Family/Peer Relationships

Asthma
Emergency Care Plan
for School/Field Trips

Name of Student _____ School _____

Teacher/Grade _____ Date _____

Dear Parent:
We understand that your child has asthma. Please complete this form and return it to school as soon as possible.
If your child needs medication at school, we must have a completed medication authorization form.
It is your responsibility to inform after school staff regarding your child's medical needs.

_____
School Nurse
Phone

____ Student carries inhaler. (The school will assume no responsibility for students who self medicate.)

____ Student has an inhaler located in _____

____ Student does not have an inhaler.

____ Student no longer requires medical intervention/medication for asthma.

Asthma Triggers (Circle asthma triggers):
Allergies, exercise, infection, changes in temperature, fragrances

What you may see/hear (Circle warning signs):
Wheezing (high pitched noise with breathing), excessive coughing, difficulty breathing, "tight chest" feeling
and/or struggling to breathe

Interventions:

- Keep student calm and resting in a comfortable position. **Do not leave student alone.**
- Ask student if he has an inhaler. If so, tell him to use it.
- Offer sips of water, caffeinated coffee, tea or soda, preferably at room temperature.
- **If symptoms continue, notify parent and call first responders.**
- If student is unable to speak, anxious, lips are blue or inhaler has not helped, **call first responders and 911.**

The school nurse may communicate with the student's health care provider(s):
Dr._____ Phone _____
Parent/Guardian Signature _____**Date** _____
_____

GUILFORD COUNTY SCHOOLS
AUTHORIZATION OF MEDICATION FOR A STUDENT AT SCHOOL

Check one:____Prescription____Non-Prescription

School:_____School Address: _____

Name of Student:_____ Date of Birth: _____

IN ORDER TO KEEP THIS STUDENT IN OPTIMUM HEALTH AND TO HELP MAINTAIN MAXIMUM SCHOOL PERFORMANCE, IT IS NECESSARY THAT MEDICATION BE GIVEN DURING SCHOOL HOURS.

NOTE: Please Complete a Separate Form for each Medication

PRESCRIBER INSTRUCTIONS:
Prescribing Health Care Clinician (print):_____Phone: _____

Medication: _____Diagnosis: _____

Dosage, Time, and Method of Administration: _____

Expected Dates for Administration:_____

List Any Possible Adverse Reactions That Should Be Reported to Health Care Clinician: _____

_____

☐ Check here if serious reaction can occur if medication not given exactly as prescribed.

☐ Check here if serious reaction can occur even when medication is administered properly.

☐ Student has been instructed, understands and has demonstrated the skill to self administer his/her emergency medication.

Special handling instructions: _____

NOTE: The health care clinician may use another format (computer printout, letter, etc.) to authorize administration of the medication. However, all information requested above must be provided.

_____
Signature of Health Care Clinician Date Phone

PARENT'S PERMISSION
I hereby give my permission for my child (named above) to receive medication during school hours. This medication has been prescribed by a licensed physician or other health care clinician. I hereby release the Board of Education and their agents and employees from any and all liability that may result from my child taking the prescribed medication.

_____
Signature of Parent or Guardian Date Phone

(SCHOOL USE ONLY)
Name and title of person(s) designated by principal to administer medication: _____

_____

☐ Student has demonstrated to the school nurse the skill to self administer his/her emergency medication.

Content reviewed by: _____
Signature of School Health Nurse Date

Withdrawal of authorization was made in writing (attach note from parents): _____
Date

In 2015- 2016, there were 58,530 procedures (tube feedings, urinary catheterizations, etc.) performed by school staff as trained by school nurses. We need health care provider order to provide service in school.

Guilford County Schools

MEDICAL ORDERS

Student Name: _____Date of Birth: _____

Physician/Licensed Health Care Clinician Name (**printed**) _____

Phone (____) _____ Fax (____) _____

Address: _____

CLINICIAN SIGNATURE_____ Date: _____

.....

PARENT/GUARDIAN PERMISSION:
I hereby give my permission for the school nurse or trained school employee(s) to carry out the above orders for my child (named above) during school hours. These orders have been prescribed by a licensed physician or other health care clinician.

PARENT/GUARDIAN SIGNATURE: _____ Date**:** _____

.....

School Nurse Signature _____ Date: _____

Communicable Disease Surveillance

- Work with Public Health Communicable Disease Program to control reportable diseases.
- Provide surveillance when there is an outbreak to determine individuals in schools at risk of exposure.
- Educate the school staff and families about disease prevention.

School Nurses in 2015 -2016

* Screened visions for 20,581 students
* Referred 2,059 students to an eye care provider
* Helped to secure resources for many families

What Else Do We Do?

- We respond to the health of the community in Guilford County as DHHS Public Health Nurses.
- We also assist with the immunization clinics, emergency shelters, and present at health fairs.

Advocates for Children

- The School Nurses are continuously advocating for our students. A working partnership with all health providers in our community can make a difference in the lives of children and enhance their ability to become a healthy and successful adult.

Request/Referral to School Nurse

To GCDHHS
School Health Program

Date _____

School _____

Name of Student Referred/DOB

_____

Student's Diagnosis

_____

_____

Parent or Guardian of Student Referred

_____

Home Telephone

_____

Work/Cell Telephone

_____

Reason(s) for Referral – From Health Care Provider

_____

_____

_____

_____

_____

_____
Signature

Assessment/Findings Per School Nurse

_____

_____

_____

_____

_____

Date Signature

SEND REQUEST TO

GCDHHS – School Health
Phone 336 641-3896
Fax 336 641-6050

RETURN FINDINGS TO

Name _____
Phone _____
Fax _____

2/14 Updated 6/16

School records are protected by:

Family Educational Rights and Privacy Act (FERPA)

School records, including immunization records, cannot be released without a parent signature.

School Nurses share information with school staff on a need to know basis.

School nurses collaborate with multiple community service providers including:

- Juvenile Justice System
- Children's Mental Health Collaborative
- YMCA Adolescent Program Advisory Board
- Wrap Around for Triad Adult Pediatric Medicine
- Pediatric Team with Partnership for Community Care
- Child Fatality Prevention Team
- Guilford County Asthma Coalition

Healthy Children Learn Better

A student's health status is directly related to his or her ability to learn. The school nurse supports the physical, mental, emotional, and social health of students and their success in the learning process.

How Can You Contact Us?

Susan Hawks, RN, BSN, NCSN

Lead School Nurse Supervisor

(336) 641-3896

shawks@myguilford.com

- **Janis Surratt – High Point Supervisor**
- **Beth Jaekle – Greensboro Supervisor**

Resource Information

School Health Program

http://www.myguilford.com/humanservices/health/child-health-services/school-health/