

Chagrin Falls Exempted Village Schools

Dear Parent,

Office of Pupil Services

As a district we are committed to insuring that we are proactive in addressing the needs of students who have medical conditions that may result in emergency situations. In order to increase the consistency of service provision across the district, we have redesigned our procedures for documenting student needs.

In order to address the medical needs of your child while at school, please complete the enclosed form(s) indicated below. These forms may be returned to your child's school, attention to Julie Gosnell, School Nurse, or to the Pupil Services Office at 400 East Washington Street during the summer. **We are interested in having all forms received prior to the start of school in August in order to ensure that we are prepared to meet the needs of each student on the first day of school.** As in the past, you will need to personally deliver your child's medication, in its original container, to your child's school in August.

- Request for the Administration of Medication by School Personnel
- Emergency Health Care Action Plan - Allergy Alert
- Self-Administration Form for Anaphylaxis Medication
- Emergency Health Care Action Plan - Asthma Alert
- Self-Medication for Asthma Inhaler
- Emergency Health Care Action Plan - Medical Alert
- Emergency Health Care Action Plan - Diabetes Alert

If your child participates in extracurricular or after-school activities, we encourage you to provide the activity coordinator with a copy of your child's medical forms, medication, and appropriate training. We will be happy to provide copies of the documents for you to share with the providers if requested. It is the responsibility of parents/guardians to make the supervisory personnel of extracurricular/outside school activities aware of your child's needs. We are not able to provide access to your child's medication from the clinic for these activities as we must insure that it is available at all times to school personnel in a consistent, easily accessible location.

Please also be aware that transportation personnel are alerted to the life-threatening medical needs of students and provided training regarding how to recognize symptoms. Bus drivers are instructed to request assistance of emergency medical personnel immediately in the event of an emergency. All of our transportation vehicles are equipped with two-way communication devices.

If you have any questions or concerns regarding the information presented here, please feel free to contact me at 44/247-4564. If you would like to speak with Julie Gosnell, the school nurse, regarding specific information about your child's medical needs, you may leave a message for her with the Pupil Services Secretary, Joanne Lynch, at 440/247-4564. Hope you have an enjoyable summer and we look forward to working with you next school year.

Information for Parents of Students with Life-Threatening Allergies

If your child has a known life-threatening allergy, you should also find enclosed our Guidelines for Managing Students with Known Life-Threatening Allergies and a blank Allergy Exposure Prevention Form. These Guidelines are based upon those developed collaboratively by the Food Allergy and Anaphylaxis Network, the National Association of School Nurses, the National School Boards Association, the American Food Service Association, and the National Association of Elementary School Principals. Although we recognize that it is virtually impossible to entirely eliminate the risk of exposure to an allergen within a public setting, the Allergy Exposure Prevention Plans are intended to reduce the likelihood of potential exposure.

The Allergy Exposure Prevention Plan lists potential recommendations to reduce exposure. Please indicate which precautionary measures you would like us to implement for your child. The completed Allergy Exposure Prevention Plan may be returned to your child's school, attention to Julie Gosnell, School Nurse, or to the Pupil Services Office at 400 East Washington Street during the summer.

Sincerely,

Christine A. Jackson, Ph.D.
Director of Pupil Services

Chagrin Falls Exempted Village Schools

Office of Pupil Services

Student:

Date of Birth:

Dear Physician,

In order to address the medical needs of this student while at school, please complete the enclosed form(s) indicated below.

- Request for the Administration of Medication by School Personnel
- Emergency Health Care Action Plan - Allergy Alert
- Self-Medication Form for Epinephrine Autoinjector
- Emergency Health Care Action Plan - Asthma Alert
- Self-Medication for Asthma Inhaler
- Emergency Health Care Action Plan - Medical Alert
- Emergency Health Care Action Plan - Diabetes Alert

Medications are routinely accessible to trained school personnel in the clinic/office area at all times and during school-sponsored field trips. *If the severity of a child's medical condition requires that s/he have **immediate** access to a medication during other school settings, multiple doses of the prescription must be provided by the parents.* If multiple doses are indicated on the attached form, but not provided by the parents, medication will be accessible at all times to trained staff in the clinic/office area only to allow for consistent readily accessible access in the case of an emergency.

Please note that state law prohibits the consumption of food and drink on the buses except in the case of medical need. Bus drivers are informed of student medical needs and are instructed to request assistance of emergency medical personnel immediately in the event of an emergency.

Thank you for your time and please do not hesitate to contact me by leaving a message with the Pupil Services secretary, Joanne, at 440/247-4564 should you have any questions.

Sincerely,

Julie Gosnell, R.N.
School Nurse

ASTHMA ALERT

<i>Chagrin Falls Exempted Village Schools Emergency Health Care Action Plan</i>	Student	Place Student's Picture Here	
MEDICAL CONDITION:			
DOB	TEACHER		
POSSIBLE SIGNS OF AN ASTHMA EMERGENCY: Difficulty breathing, walking, or talking Blue or gray discoloration of the lips or fingernails Failure of medication to reduce worsening symptoms			
Triggers	Personal Best Peak Flow		
ACTION - To Be Completed By Physician - Include Medication and Care Instructions along with accompanying Medication Administration for School Personnel and/or Self -Adminsitration Forms			
Steps to be followed in the event of an asthma emergency: 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____			
PHYSICIAN - PLEASE INCLUDE ACCESS TO MEDICATION INFORMATION			
<input type="checkbox"/> Accessible at all times in clinic. <input type="checkbox"/> Accessible during field trips. <input type="checkbox"/> Attached self-administration form.* * <i>Requires parental provision of multiple doses</i>	Bus drivers are informed of student medical needs and are instructed to request assistance of emergency medical personnel immediately in the event of an emergency.		
Physician's Printed Name	Physician Phone		
Physician Signature	Date		
<i>DO NOT HESITATE TO ADMINISTER ABOVE MEDICATION AND CALL RESCUE SQUAD IN AN EMERGENCY!</i>			
Parent/Guardian Signature	Date		
Emergency Contacts			
Name	Relationship	Phone	Cell Phone
	Mother / Guardian		
	Father / Guardian		
Trained Staff Members - Others not listed may also be trained.			Recess
Classroom(s)		Transportation	
Cafeteria		Office	

Chagrin Falls Exempted Village Schools
Request for the Administration of Medication by School Personnel

<p align="center">TO BE COMPLETED BY PHYSICIAN</p> <p>The student indicated above is under my care and should receive the medication indicated below. It is not possible to arrange for this medication to be taken at home under the supervision of a parent, and therefore, must be taken during school hours.</p>	Student
	Homeroom Teacher
	Date of Birth

Address:

City/State/Zip Code:

Name of Medication:	
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Dosage:	
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Number of Times or Interval Medication is to be given:	
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Date to Begin Administration:	
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Date to End Administration:	
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Adverse reactions that should be reported to Physician:	
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Special instructions for the administration of medication:	
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Physician's Printed Name	Phone
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Physician Signature	Date	Fax
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TO BE COMPLETED BY PARENT/GUARDIAN
Parent Contact Information

Name	Relationship	Phone	Work Phone	Cell Phone
	Mother / Guardian			
	Father / Guardian			

The parent/guardian(s) agree to submit a revised statement by the physician who prescribed the drug to the person designated to administer medication if any of the information provided by the person licensed to prescribe medication as described above changes.

Parent/Guardian Signature	Date
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Chagrin Falls Exempted Village Schools Self-Administration for Asthma Inhalers - Authorization Form	
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<p style="text-align: center;">TO BE COMPLETED BY PHYSICIAN</p> <p>The student indicated above is under my care and should be given consideration to carry and self-administer the medication prescribed below. It is not possible to arrange for this medication to be taken at home under the supervision of a parent, and therefore, must be taken during school hours.</p>	Student
	Homeroom Teacher
	Date of Birth

Address:

City/State/Zip Code:

Name of Medication:	
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Dosage:	
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Date to Begin Administration:	Date to End Administration:
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Adverse reactions that should be reported to Physician:	
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Adverse reactions for unauthorized user:	
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Procedure to follow in the event that medication does not produce the expected relief from the asthma attack:	
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Other special instructions:	
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Physician's Printed Name	Phone
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Physician Signature	Date	Fax
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TO BE COMPLETED BY PARENT/GUARDIAN
Parent Contact Information

Name	Relationship	Phone	Work Phone	Cell Phone
	Mother / Guardian			
	Father / Guardian			

The parent/guardian(s) agree to submit a revised statement by the physician who prescribed the drug to the person designated to administer medication if any of the information provided by the person licensed to prescribe medication as described above changes.

Parent/Guardian Signature	Date
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