Rosewood Elementary

Health Room News 2023-2024

Important Reminders regarding medication at school

IF POSSIBLE, THE PARENT SHOULD GIVE MEDICATIONS BEFORE OR AFTER SCHOOL HOURS.

*All medications require a permission form to be completed **PRIOR** to any medication given during the school day. The medication form is on the Richland One website as well as the Rosewood website.

Prescription medications require the signature of the healthcare provider AND the parent/guardian BEFORE it can be given at school. Prescribed medications should be in the properly labeled container from the pharmacy, including the name of the student, name of the drug and the time to be given.

Over the counter medications such as Tylenol/Advil require the signature of the parent/guardian. These medications **MUST be in the original container** and the permission forms completed to coincide with the label instructions and age recommendations.

*Initial doses of a medication that a child has never taken before should NOT be given on a school day.

*A separate form must be completed for each medication.

*Space for medication storage in school settings is limited; therefore, to the extent possible, medication quantities to be stored at school should be limited.

*Prescriptions and medication permission forms must be renewed each school year.

*Schools may decline to administer certain medications if deemed inappropriate for a school setting.

*Medications that make students drowsy and unable to participate in educational activities may not be appropriate for school administration.

*A responsible adult should deliver the medicine and permission form to the school. The medicine must be in the **original container** with the manufacturer's label intact.

*The school does NOT stock any medications; therefore, you must bring in any medication that is necessary for your child.

*Students cannot transport medication home at the end of the day. If the student needs the medication after school hours, a responsible adult MUST pick up the medication.

*Please do not send medication in your child's pocket, lunch box or wrapped in foil, saran wrap or plastic bags to be given/taken.

*Parents must count medications with the school nurse when bringing in controlled substance medications.

OTHER REMINDERS:

***Please remember to update/keep your contact information current.** If contact information changes during the school year, we should be the first place you call. When a student becomes ill or injured, the school will notify you or the alternate contact person to pick up the student. It is VERY important that we have the name and phone number of someone (who has agreed) that we can reach during school hours if an emergency occurs. These phone numbers MUST be kept up to date. If your child has any changes in health status (injuries and/or surgeries included) during the school year, please notify the nurse.

*The health room is a stepping stone to getting your student back to class or home when they are sick or injured. It is not for students requiring extended care or for students who want to sleep because they didn't get enough sleep during the night.

*Richland County School District One follows the South Carolina DHEC School Exclusion list. Copies of the DHEC Exclusion list can be found on the DHEC website.

(https://scdhec.gov/health/child-teen-health/school-exclusion)

The Rosewood website also has a direct link to the DHEC website and copies of the School Exclusion List are available outside the health room door.

*Student concerns are triaged upon arrival to the health room with the goal of the student returning to class as quickly as possible to continue his/her educational activities.

Please feel free to contact me if I can be of any assistance to you or your student.

Diane Reaves RN
School Nurse

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Last School Attended _____

ROSEWOOD ELEMENTARY SCHOOL
2023-2024
Richland County School District One

CONFIDENTIAL HEALTH QUESTIONNAIRE FOR SCHOOL NURSE ONLY

STUDENT NAME_____ BIRTHDATE ____/____/_____

MALE ☐ FEMALE ☐ RACE_____ GRADE _____ HOMEROOM TEACHER _____

ADDRESS_____
ZIP CODE_____ HOME PHONE_____

STUDENT LIVES WITH (CIRCLE ONE): MOTHER FATHER BOTH PARENTS OTHER_____

MOTHER/ LEGAL GUARDIAN'S NAME _____EMPLOYER _____
WORK NUMBER_____ CELL PHONE_____ E-MAIL _____

FATHER/ LEGAL GUARDIAN'S NAME _____EMPLOYER _____
WORK NUMBER_____ CELL PHONE_____ E-MAIL _____

STEP PARENT (living with child) NAME _____ PHONE # _____

LIST THE NAME(S) OF ANY SIBLINGS AT PRESENT SCHOOL: _____

HEALTH CARE PROVIDER/NURSE PRACTITIONER_____
TELEPHONE NUMBER_____ LAST PHYSICAL/VISIT _____
DENTAL CARE PROVIDER_____
TELEPHONE NUMBER _____ LAST VISIT _____ (RECOMMENDED CLEANING EVERY 6 MONTHS)
MEDICAID (CIRCLE ONE) Y / N POLICY NUMBER_____
PREFERRED HOSPITAL (non-emergency situation) _____

LIST 2 AUTHORIZED PEOPLE TO ASSUME RESPONSIBILITY AND PICK UP YOUR CHILD IN CASE OF AN ILLNESS/EMERGENCY WHEN THE PARENT/GUARDIAN CANNOT BE REACHED

1. NAME _____RELATIONSHIP TO STUDENT _____
   PHONE NUMBER (WORK)_____(HOME)_____ (CELL)_____
   ADDRESS_____

2. NAME _____RELATIONSHIP TO STUDENT _____
   PHONE NUMBER (WORK)_____(HOME)_____ (CELL)_____
   ADDRESS_____

(PLEASE COMPLETE THE BACK OF THIS FORM) OVER

Reviewed By: _____ Date: _____ School Year: 2023-2024

Please check (√) and explain any health conditions **DIAGNOSED BY A LICENSED HEALTHCARE PROVIDER** (Doctor or Nurse Practitioner)

Check	Condition	Explain
	ADD/ADHD	(CURRENT MEDICATION):
	ALLERGIES SEVERE REQUIRING AN EPI-PEN (Extra should be kept at school)	☐ Food: ☐ Insects: ☐ Seasonal:
	ANEMIA (LOW BLOOD)	
	ASTHMA (Inhaler should be available at school with completed medication forms on file)	Medication: Last Attack: ____/___/_____
	BLADDER/URINARYCONDITION	
	BONE/ORTHOPEDIC CONDITION	
	DIABETES (SUGAR)	Medication:
	EPILEPSY(SEIZURES)	Last Episode: ____/___/_____ Medication:
	FAINTING SPELLS (Syncope)	
	GENETIC CONDITION	
	HEART TROUBLE	Corrected: Y / N
	HEMOPHILIA/BLEEDING DISORDER	
	HIGH BLOOD PRESSURE	
	MENTAL HEALTH ILLNESS	DIAGNOSIS:
	PROBLEMS WITH VISION	GLASSES: Y / N - LAST EXAM: ____/___/_____
	PROBLEMS WITH HEARING	HEARING AID: Y / N EAR: ☐ RIGHT ☐ LEFT
	REACTIVE AIRWAY DISEASE	
	SICKLE CELL	Last Crisis: ___/__/___ Last Hospitalization: ___/___/___
	SICKLE CELL TRAIT ONLY	
	SKIN DISORDER	
	TUBERCULOSIS (TB)	
	OTHER:	

Does your child take any daily medications? ☐ No ☐ Yes – List medication and dosage:

_____

_____

_____

Medication given at: ☐ Home ☐ School ☐ Only in Emergency

When possible, the parent/legal guardian should arrange for the student to receive medication before or after school hours.

Medication should be brought to the health room in its original container and the appropriate forms should be completed prior to a student receiving medicine at school. Parental consent is required for non-prescription medication and both parental and student's healthcare provider signatures are required for prescription medication. Students that will self-medicate/carry his or her meds while at school (i.e. albuterol inhaler) should have a **"parental release"** and **"self-medicating and/or self-monitoring"** forms completed by the parent, health care provider and student.

I GIVE THE SCHOOL NURSE PERMISSION TO CONTACT THE LICENSED PRESCRIBER AND/OR SHARE THE ABOVE INFORMATION WITH SCHOOL STAFF AND DISTRICT STAFF AS NECESSARY FOR MEETING MY CHILD'S EDUCATIONAL NEEDS.

PARENT/ LEGAL GUARDIAN'S SIGNATURE _____ DATE _____

Dental Treatment Consent Form

Dear Parent/Guardian:

Dental Access Carolina offers complete general dental services on-site at your child's school. Our mobile clinics are equipped with everything necessary to provide preventive and restorative dental treatment. **If your child is enrolled in SC Medicaid, there is no cost to you!** We also accept private insurance from all major insurance carriers.

A team of professionals, **led by an experienced doctor**, will visit the school on a regular basis throughout the school year to provide dental services, including exams, x-rays, cleanings, fillings and more. You will receive a detailed report of any treatment your child receives after each visit.

☐ **Yes** – I want my child to receive dental care from Dental Access Carolina

- I am the legal guardian of my child
- I **understand and consent** to the information on this form

Sign this form, fill out front and back, and return to your child's teacher or school nurse

☐ **No** – I do not want my child to receive dental care from Dental Access Carolina

Child's Full Name:_____

Write your child's name above, then return this form to your child's teacher or school nurse

Signature of Parent/Guardian_____ Date _____

Printed Name of Person Completing Form_____

If you checked "YES", please fill out the blue box below AND the medical history on the back. SIGN the form and return to school!

Child's Full Name _____ Birthdate (mm/dd/yy)_____ / _____ / _____

School_____ Grade_____ Teacher _____

SC Medicaid # _____ (Include **ALL 10 Digits**)

OR

Insurance Company _____ Ins Co Phone _____

Subscriber name _____ Subscriber ID _____

Subscriber Social Security #_____ Subscriber Birthdate (mm/dd/yy) _____ / _____ / _____

Employer _____

Group Name _____ Group # _____

Patient's Relationship to Subscriber: [ ] Self [ ] Spouse [ ] Child

Parent or Guardian Name_____ Phone _____

Home Address _____ City_____ Zip _____

Email Address _____ Consent to Contact via Email? □ Yes □ No

Emergency Contact _____ Phone _____

PLEASE COMPLETE PATIENT'S MEDICAL HISTORY ON THE BACK OF THIS PAGE.

*I understand and **authorize** Dental Access Carolina, LLC ("Provider") to provide dental care and treatment for the child listed above, and I certify that I am authorized to give such consent. I understand that the dental treatments which may be provided could generally include dental exams, x-rays, cleanings, dental sealants, fluoride treatment, fillings, extractions, pulpotomies and root canal treatments. I understand and have been advised that, as with any dental treatment, these procedures may entail some risk of complications, and that a list of such potential complications can be found at www.dentalaccesscarolina.com/FAQ. I **authorize** and direct Provider to bill and collect payment from Medicaid, insurance, or any other payer. I hereby authorize release of any information that will assist in treatment or in processing of claims for services rendered. If I have private dental insurance, I understand that I am responsible for any balance deemed patient responsibility/non-payable/non-covered by insurance. I understand that photographs may be taken for educational or documentation purposes and give consent. I have provided an updated medical history form to Provider (see reverse page). Provider is **authorized** to rely on said medical history form until notified of any change in writing. This signed consent **authorizes** treatment for my child at my child's initial and future dental visits. I may withdraw this consent at any time prior to treatment in writing.*

DENTAL ACCESS CAROLINA, LLC—PATIENT'S MEDICAL INFORMATION

Name _____ _____ _____ Birthdate (mm/dd/yy) ____/____/____
First Middle Last

Sex _____ Height _____ Weight _____ Race (Circle One) White Black Hispanic Other _____

Name of Physician _____ Phone _____ Last Seen _____

Date of Last Dental Visit _____ Name of Dentist _____ City _____

PATIENT'S MEDICAL INFORMATION

Yes No

____ ____ Have you been seriously ill in the last 5 years? If yes, explain: _____

____ ____ Have you ever been hospitalized or had a serious illness? If yes, explain: _____

____ ____ Has a doctor told you to take antibiotics before ALL dental treatments?

ARE YOU TAKING ANY OF THE FOLLOWING MEDICATIONS?

Yes	No		Yes	No	
____	____	Antibiotics (Penicillin, etc.)	____	____	Insulin (Diabetes Medication)
____	____	Anticoagulants (blood thinners)	____	____	High Blood Pressure Medications
____	____	Antihistamine (Benadryl, etc.)	____	____	Nitroglycerine
____	____	Aspirin (Advil, Nuprin, etc.)	____	____	Sulfa Drugs
____	____	Cortisone (Steroids)	____	____	Tranquilizers
____	____	Digitalis (Heart Medicine)	____	____	Other, Please list _____

ARE YOU ALLERGIC OR HAVE YOU REACTED ADVERSELY TO?

Yes	No		Yes	No		Yes	No	
____	____	Antibiotics (Penicillin, etc.)	____	____	Local Anesthetics	____	____	Latex
____	____	Barbituates (Sleeping pills)	____	____	Narcotics (Codeine, etc.)	____	____	Red Dye
____	____	Sulfa Drugs	____	____	Other, Please list _____			

DO YOU HAVE OR HAVE YOU HAD?

Yes	No		Yes	No		Yes	No	
____	____	AIDS/HIV Positive	____	____	Asthma/Hay Fever	____	____	Drug Interactions
____	____	Chemotherapy	____	____	Allergies	____	____	Epilepsy Seizures
____	____	Bleeding Problems	____	____	Cortisone/Steroids	____	____	Frequent Fainting
____	____	Anemia	____	____	Cancer or Tumor	____	____	Shortness of Breath
____	____	Sugar Diabetes	____	____	Drug Addiction	____	____	Head Injury
____	____	Heart Trouble or Murmur	____	____	Hepatitis-Jaundice	____	____	Kidney Disease
____	____	Hives	____	____	Prosthetic Hip/Heart Valve	____	____	Psychological Problems
____	____	Frequent Headaches	____	____	Liver Disease	____	____	Sinus Trouble
____	____	Stroke	____	____	Rheumatic Fever/Rheumatic Heart Disease			
____	____	Thyroid Disease	____	____	Radiation for Head/Neck Cancer			
____	____	Venereal Disease	____	____	Tuberculosis/Lung Disease			

Do you have any other medical condition(s) that we should know about? If so, please explain: _____

_____

_____

_____