Student Name:_____ **Grade**_____
Date:_____

The Santa Rosa County Health Department wants to work with your family, community health care providers, and our school district to help our students become healthier. Our School District is working hard to provide healthier classrooms and healthier meal choices such as:

- **Salad bars and/or chef salad. A variety of fruits and dark green/orange vegetables**
- **Lean meats that include turkey, turkey ham, chicken breast, and reduced fat hamburger**
- **Whole grain pastas, bread, and dessert choices**
- **Only 1% or less low fat flavored and unflavored milk and 100% juice**

BMI (Body Mass Index) is a measurement tool used to help identify students who are at risk for weight-related health problems such as osteoporosis, type I diabetes, or possibly an eating disorder.

Your child was weighed and measured along with all students in their grade.*

_____ **Height** _____ **Weight**
_____ **BMI** _____ **BMI Percentile**

Based on your child's height, weight, and gender, his/her BMI was found to be lower than recommended for his/her age (less than the 5th percentile).

- underweight, less than the 5th percentile
- healthy weight, 5th up to the 85th percentile
- overweight, 85th to less than the 95th percentile
- obese, equal to or greater than the 95th percentile

Please share this result with your health care provider. If you do not have a health care provider you can seek additional insurance information at: **www.FloridaKidCare.org**

Consider this…


+ + = 450 calories
Juice


+ + = 0 calories
Water

This amount of juice is 1/3 of the calories that most kids should have in a day.
Food is the most important part of a balanced diet.

5	Servings of fruits and vegetables every day	**2**	Less than 2 hours of screen time every day	**1**	One hour of physical activity every day	**0**	Zero soda or sugar sweetened beverages every day

PARENT/GUARDIAN REPLY

Please complete the following and return this entire form to the school nurse.

Health Care Provider comments:_____
_____
Parent comments:_____
_____

Parent/Guardian Signature: _____ ***Date:*** _____

***required by the Florida Administrative Code, Chapter 64F-6.003.**

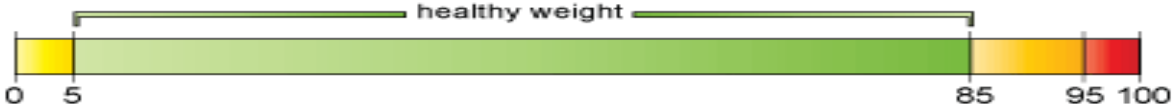
Student Name:_____ **Grade**_____
Date:_____

The Santa Rosa County Health Department wants to work with your family, community health care providers, and our school district to help our students become healthier. Our School District is working hard to provide healthier classrooms and healthier meal choices such as:

- **Salad bars and/or chef salad. A variety of fruits and vegetables including, dark green and orange vegetables**
- **Lean meats that include turkey, turkey ham, chicken breast, and reduced fat hamburger**
- **Whole grain pastas, bread, and dessert choices**
- **Only 1% or less low fat flavored and unflavored milk and 100% juice**

BMI (Body Mass Index) is a measurement tool used to help identify students who are at risk for many weight-related health problems including high blood pressure, high cholesterol, type 2 diabetes, fatty liver, and heart disease. Each year, Santa Rosa County students are becoming more overweight and obese.

Your child was weighed and measured along with all students in their grade.*



_____ **Height** _____ **Weight**
_____ **BMI** _____ **BMI Percentile**

Based on your child's height, weight, and gender, his/her BMI was found to be higher than recommended for his/her age (equal to or greater than the 95th percentile**).**

- underweight, less than the 5th percentile
- healthy weight, 5th up to the 85th percentile
- overweight, 85th to less than the 95th percentile
- obese, equal to or greater than the 95th percentile

Please share this result with your health care provider. If you do not have a health care provider you can seek additional insurance information at: www.FloridaKidCare.org

Consider this…


Juice **= 450 calories**


Water **= 0 calories**

This amount of juice is almost 1/3 of the calories that most kids should have in a day.
Food is the most important part of a balanced diet.

5 Servings of fruits and vegetables every day	**2** Less than 2 hours of screen time every day	**1** One hour of physical activity every day	**0** Zero soda or sugar sweetened beverages every day

PARENT/GUARDIAN REPLY

Please complete the following and return this entire form to the school nurse.

Health Care Provider comments:_____

_____

Parent comments:_____

_____

Parent/Guardian Signature: _____ ***Date:*** _____

***required by the Florida Administrative Code, Chapter 64F-6.003.**

BMI Coding Summary Sheet

School: School Nurse: Date Screened:

	Male E1	Female E1	Male E3	Female E3	Male E6	Female E6
O521 Normal 5%-85%						
O522 Underweight <5%						
O523 Overweight 85%-94%						
O524 Obese >95%						
Total by Category						
Total by Grade						

Santa Rosa County School Health - Scoliosis Follow-up

Name: _____ Grade: _____ Date: _____
School: _____ Teacher: _____

Dear Parent / Guardian:

Your child was screened for scoliosis during the 6th grade health screening day at school on _____ . Please let us know if your child has been seen by a doctor or if an appointment has been made to follow-up on this screening.

If finances are a problem, community resources may be available. Please contact your school health nurse.

Return this slip with parent's and/or doctor's comments to the school health clinic, or feel free to call the school health nurse listed below to discuss this referral.

Thanks for your assistance.

School Health Nurse
Santa Rosa County Health Department

Parent's Comments:

_____

_____

_____

Parent's Signature: _____ **Date:** _____

Doctor's Comments

Diagnosis: _____

Comments: _____

_____

_____

Doctor's Signature: _____ **Date:** _____

Dear Parent/Guardian of:_____

Your child has been evaluated in the School Health Clinic by a School Health Nurse from the Santa Rosa County Health Department and has a suspicious skin infection. Some skin infections are caused by Methicillin-Resistant Staphylococcus Aureus (MRSA). You do not need to be alarmed about this, but the Health Department would like to provide you with information about this type of infection.

Staphylococcus aureus ("staph") is a type of bacteria found in the environment and on the skin or in the nose of 25% to 30% of healthy individuals. It is a common cause of bacterial skin lesions, such as impetigo, furuncles, carbuncles, abscesses and infected cuts and is most commonly spread through direct physical contact (skin-to-skin) with an infected person. In the past 25 years, more and more of these staph infections have become resistant to the antibiotics commonly prescribed to treat them – penicillin and methicillin. These MRSA infections therefore require more persistence to treat and more vigilance to prevent.

It is neither practical nor necessary to bar children with MRSA infections from attending school; however, precautions need to be taken to prevent the spread to other persons. MRSA infections are treatable, and early treatment can help keep the infection from getting worse. We ask that you consult with your health care provider as soon as possible. Depending on the severity of the infection, he or she may send a sample for laboratory testing and may prescribe antibiotics. The infected area must remain bandaged until the wound is dry, especially if your student is involved in contact sports. Remember, even if the infection appears to be healing, the treatment instructions should continue to be followed to prevent the infection from coming back or becoming worse.

The following are the best ways to prevent MRSA infections:

- Wash hands frequently with soap and warm water, especially after changing your own bandages or the bandages of another person.
- Do not share personal items such as razors, towels, bed sheets, clothes, deodorant, sporting equipment.
- Wash all cuts, scratches and abrasions with soap and water. Keep them covered with a clean, dry bandage until healed.
- Avoid contact with open wounds and cuts.
- Wash soiled towels, bed sheets, and clothes in hot water with soap and bleach. Dry clothes in a hot dryer, heat helps kill the bacteria.
- Never touch, squeeze or pop any boils. This can spread the bacteria to other parts of your body or to other people. The pus is full of bacteria.
- Keep all common areas, like bathrooms and kitchens clean. A 1:10 bleach solution or chemical germicide will kill the bacteria.

If you have any questions, please contact your physician, or your School Health Nurse at 983-5200.

_____ KINDERGARTEN REGISTRATION

School _____ Date _____

	Student Name	Parent Name	Phone #	Allergies	Shots	CP	P	Medical History
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								

_____ KINDERGARTEN REGISTRATION

School _____ Date _____

	Student Name	Parent Name	Phone #	Allergies	Shots	CP	P	Medical History
21								
22								
23								
24								
25								
26								
27								
28								
29								
30								
31								
32								
33								
34								
35								
36								
37								
38								
39								
40								

_____ KINDERGARTEN REGISTRATION

School _____ **Date** _____

	Student Name	Parent Name	Phone #	Allergies	Shots	CP	P	Medical History
41								
42								
43								
44								
45								
46								
47								
48								
49								
50								
51								
52								
53								
54								
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56								
57								
58								
59								
60								

DIASTAT and DIASTAT ACUDIAL SKILLS CHECKLIST

Trainee's Name: _____ Date: _____
(Please Print)

Trainee's Signature: _____ Trainee's Initials: _____

EXPLANATION/RETURN DEMONSTRATION	TRAINEE'S INITIALS
1. Observe student for signs/symptoms of seizure activity (Note time of onset)	
2. Call or delegate someone to call 911 and parent/guardian; notify school site administration staff.	
3. Check medication expiration date, physician's order, and student's *Emergency Health Care Plan*	
4. Place student on left side	
5. Provide privacy	
6. Prepare Diastat for administration (If using Diastat AcuDial confirm dosage is visible and correct in display window and the green {ready} band is visible) -Remove cap -Lubricate tip with gel if not self-lubricating -Separate buttock -Insert tip into rectum -Inject Diastat slowly – count 1-2-3 -Hold applicator still – slowly count 1-2-3 -Remove applicator slowly -Hold buttocks together – slowly count 1-2-3	
7. Stay with student until help arrives -Monitor respiratory status -Monitor seizure activity -Clear immediate area to prevent harm	
8. Report the following to EMS -Appearance of seizure activity -Time seizure began and ended	
9. Give the Diastat container with the time of administration to EMS	
10. Document on appropriate form: time of onset, symptoms observed, time medication administered, response to medication, time EMS arrived/transport	

Instructor's Name: _____
(Please Print)

Instructor's Signature: _____

Rev 05/15/2013

EPIPEN/EPIPEN JR. INJECTION SKILLS CHECKLIST

Trainee's Name: _____ Date: _____
(Please Print)

Trainee's Signature: _____ Trainee's Initials: _____

EXPLANATION/RETURN DEMONSTRATION	TRAINEE'S INITIALS
1. Observe student for signs/symptoms of anaphylactic reaction	
2. Call or delegate someone to call 911 and parent/guardian; notify school site administration staff	
3. Check medication expiration date, physician's order and student's *Emergency Health Care Plan*	
4. Immobilize student prior to injection	
5. Determine appropriate injection site	
6. Prepare Epipen/Epipen Jr. for administration -Carefully remove auto-injector from the carrier tube or case -Grasp the auto-injector in your fist with the orange tip pointing downward -With the other hand, remove the blue safety release by pulling straight up without bending or twisting it -**NOTE** that the needle comes out of the orange tip. **NEVER** put your thumb, finger or hand over the orange tip	
7. Administer injection intramuscularly ***(Injection can be given through clothing)*** -Hold the auto-injector with the orange tip near the outer thigh -Swing and firmly push the orange tip against the outer thigh until it clicks -Keep the auto-injector firmly pushed against the thigh at a 90 degree angle (perpendicular) to the thigh -Hold firmly against the thigh for approximately 10 seconds to deliver the full dose of medication -Remove the auto-injector from the thigh. The orange tip will extend to cover the exposed needle if the correct/full dosage has been administered -Gently massage the injection site	
8. Stay with student until EMS arrives -Send Epipen/Epipen Jr. with EMS upon transfer	
9. Continuously monitor student's: breathing, color, hives, swelling, and vomiting	
10. Document on appropriate form: onset time of the reaction, symptoms observed, time and dosage of medication administered, response to medication, time EMS arrived, time EMS transported student	

Instructor's Name: _____
(Please Print)

Instructor's Signature: _____

Rev 05/15/2013

AUVI-Q AUTO-INJECTOR SKILLS CHECKLIST

Trainee's Name: _____ Date: _____
(Please Print)

Trainee's Signature: _____ Trainee's Initials: _____

EXPLANATION/RETURN DEMONSTRATION	TRAINEE'S INITIALS
1. Observe student for signs/symptoms of anaphylactic reaction	
2. Call or delegate someone to call 911 and parent/guardian; notify school site administration staff	
3. Check medication expiration date, physician's order and student's *Emergency Health Care Plan*	
4. Immobilize student prior to injection	
5. Determine appropriate injection site	
6. Prepare Auvi-Q for administration -Pull Auvi-Q from the outer case (once the outer case is off voice instructions will guide you step by step through the injection process) -Pull firmly to remove the Red safety guard -**NOTE** that the needle comes out of the black base. **NEVER** put your thumb, finger or hand over the black base	
7. Administer injection intramuscularly or subcutaneously ***(Injection can be given through clothing)*** -Place black end against the middle of the outer thigh -Press firmly and hold in place for 5 seconds -Auvi-Q makes a distinct sound (click and hiss) when activated. This is normal and indicates Auvi-Q is working correctly. Do not pull Auvi-Q away from the student's leg when you hear the click and hiss sound	
8. Following complete administration of the Auvi-Q, the black base will lock into place, the needle will retract, the voice instruction system will confirm Auvi-Q has been used and the LED lights will blink red -Stay with student until EMS arrives -Send Auvi-Q with EMS upon transfer	
9. Continuously monitor student's: breathing, color, hives, swelling, and vomiting	
10. Document on appropriate form: onset time of the reaction, symptoms observed, time and dosage of medication administered, response to medication, time EMS arrived, time EMS transported student	

Instructor's Name: _____
(Please Print)

Instructor's Signature: _____

Rev 05/15/2013

School Health Care Plan Log Sheet

School:_____ School Nurse:_____

School Year: _____

	Student Name	Grade	Teacher	Health Concern	Contacted (1st Attempt)	2nd Attempt	3rd Attempt	Done
1								
2								
3								
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25								

Print front & back

School Health Care Plan Log Sheet

School:_____ School Nurse:_____

School Year: _____

	Student Name	Grade	Teacher	Health Concern	Contacted (1st Attempt)	2nd Attempt	3rd Attempt	Done
1								
2								
3								
4								
5								
6								
7								
8								
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25								

Print front & back

Refer to Section XV to access the Health Care Plan Forms:

For Emergency Health Care Plans that require emergency medications, health staff will make three (3) attempts to contact parent/guardian to collect the medication(s). If medication is not collected, the Emergency Health Care Plan can be revised to note “Contact EMS/911 as appropriate.”

Employee Activity Record

Submit at the end of the day to Lisa_Schofield@doh.state.fl.us
and cc Deborah_Price@doh.state.fl.us and Kristie_Beckstrom@doh.state.fl.us

Employee Name	Position Number	Service Unit	Date

Services Provided	Program Code	Service Code	# of Services	FTTY	Location	Time
On site	34					
	34					
	34					
	34					
	34					
	34				92	
	34				92	
	34				92	
	34				92	
	34				92	
	34				92	
	34				92	
	34				92	
	34				92	

Total Time Worked

I hereby certify that I have accurately recorded time worked on the attached Employee Activity Record (EAR) and that this record reconciles to my official timesheet. The EAR is being emailed for data entry by the designated CHD staff since I have not had access to the DOH intranet during the EAR submission timeframe for this pay period.

Program Code	Service Code	Age/Grade	Sex	# of Services	FTTY	Results	Outcome	Location
34								92
34								92
34								92
34								92
34								92
34								92
34								92
34								92
34								92
34								92
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34								92

SCHOOL NURSE:

SCHOOL NURSING ACTIVITY REPORT FOR: Month _____ School _____

1. Total School Visits:
2. Health Care Plans (5053): Title I/X students: _____
3. Vision Screenings:(0510): Title I/X students: _____
4. Vision Referrals:
    a. # VSP-Sight for Student certificates issued:
5. Hearing Screenings (0515): Title I/X students: _____
6. Hearing Referrals:
    a. # SRCSD Audiology clinic referrals
7. Scoliosis Screens (0561): Title I/X students: _____
8. Scoliosis Referrals:
9. Record Reviews (0598):
10. Immunization Records review/follow-up (5033):
11. Nursing Consults/Referrals (5051): Title I/X students: _____
12. Nursing Assessments (5000): Title I/X students: _____
13. School presentations/#/attendees (8020):
    a. Class Name:
    b. # Attended:
14. Other: Community Presentation (7500):
15. Conference/Meeting (8070):
16. Child Specific Training (8080): Title I/X students: _____
17. Health Literacy reading (8025) #classes/#participants
18. BMI Calculations- # of services:
19. Refusals for health services-#:
20. # Pregnant students
21. # Births to teens
22. Miscellaneous:

ACKNOWLEDGEMENT OF MEDICATION ADMINISTRATION TRAINING

Trainee's Name: _____ Date: _____
(Please Print)

Trainee's Signature: _____ Trainee's Initials: _____

I hereby acknowledge that I have received training concerning medication administration at the school. I understand that I must follow the guidelines provide by the Santa Rosa County School District Board and Pediatric Services of America in accordance with State Law 323.46 and School Board Policy 5.62.

THE SEVEN (7) RIGHTS	EXAMPLE	INITIALS
Right Student	Never give the medication if there is any doubt as to the student's identity. Ask the name, then compare to the bottle label and paperwork.	_____
Right Medication	Do not ever substitute a student's medication with another person's medication.	_____
Right Dosage	Check the dosage on the label carefully. Compare paperwork with the medicine container label. Always administer as per medication label. Administer exactly as called for; no more, no less.	_____
Right Time	Check the time with the label and written orders. A grace period of thirty minutes before or after the stated time is allowed. Certain abbreviations may be used.	_____
Right Route	There are different routes or methods to administer medications. Follow the label orders precisely.	_____
Right Form	There are different forms of medication, for example: tablets, capsules, caplets, syrup, suppositories, etc.	_____
Right Documentation	Document date, time, and initial/sign the Medication Administration Record when medication is administered.	_____

Instructor's Name: _____
(Please Print)

Instructor's Signature: _____

EPIPEN/EPIPEN JR. AND AUVI-Q ADMINISTRATION TRAINING

SCHOOL: _____

	Trainee's Name (Printed)	Trainee's Signature	Instructor's Name	Instructor's Signature	Date
1.					
2.					
3.					
4.					
5.					
6.					
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17.					
18.					
19.					
20.					

Rev 05/15/2013

Santa Rosa County School District

Medication Error Report

**** This form must be completed and submitted to your immediate supervisor within 24 hours****

Name of School	Date of Event	Time of Error

Name of Student	D.O.B	Prescribed Medication/Dosage/ Route/Time on Dispersion of Medication Form

Name and Position of Person Witnessing Event	Medication/Dosage/Route/Time Given

Describe event and circumstances leading to error:

Describe Action Taken:

Medication Error Codes (Circle all that apply):

1. **Wrong Student**
2. **Wrong Dose**
3. **Wrong Time**
4. **Wrong Medication**
5. **Missed Medication**
6. **Parent Error**
7. **Pharmacy Error**
8. **Other**

Signature (Person Completing Report)	Date Completed

**** <u>DO NOT</u> place this information in the student's Cumulative Health Folder.**

Rev 05/15/13

School: _____ Group Health Services Log Reported by: _____

Please complete this form and submit to Debbie Price, RN, BSN, NCSN at: priced@mail.santarosa.k12.fl.us no later than _____

Date of Class	Class Code	School Type (Elem., Middle, or High)	School	Class Title	# of classes	Grade	# of students FTTY	# of parents FTTY	# of staff FTTY	Presenter	Curriculum Book or Video Used

Codes:

100 Dental

200 General

300 Injury Prevention/ Safety

400 Mental Health

500 Nutrition

600 Physical Activity

700 Violence Prevention/ Conflict Resolution

702 Date Rape

703 Child Abuse

801 Alcohol, Tobacco & other Drug use

804 Suicide Prevention

805 HIV/STD

806 Pregnancy Prevention

808 Human Sexuality

900 Staff Wellness

901 Staff Inservice

902 Parenting Skills

Appendices