Greetings from the Health Office

Welcome to the 2020-2021 school year at Noah Webster Schools (NWS). I would like to take this opportunity to share with you some important information regarding the Health Office.

- A member of the health office is on campus to meet your student's health needs during normal school hours. You may reach a team member as follows:
  - Mesa Health Office: **NurseMesa@noahwebster.org** 480-986-2335, ext. 2111
  - Pima Health Office: **NursePima@noahwebster.org** 480-291-6900, ext. 3117
    - The health office is available from 8am-4pm, except on early release days.

- During the registration process you completed health information pertaining to your student. If any of this information has changed or changes throughout the year, please ensure the Health Office is updated.

- Per NWS Policy, students are not permitted to carry any medication, prescription or over the counter, (including cough drops) with the exception of emergency medication. A carrying permit must be on file giving them permission to carry an Epi Pen or Inhaler, please contact the Health Office for more information.

- If your child needs prescription medication while at school, proper documentation must be on file in the Health Office. Medication cannot be given unless the proper forms are in place.
  - All prescription medication must be in a valid, labeled pharmacy container. This includes Inhalers and Epi Pens.
  - **All medication must be dropped off and picked up by an adult through the front office**.
  - Medication that is to be given one time daily is to be given at home, unless other arrangements have been made.

- Please inform the health office if your child will be out for an extended time due to illness, have frequent absences due to a documented chronic medical condition, has any surgical procedures or hospitalizations.
  - Please note that medical clearance is needed following any hospitalization and/or surgeries.
  - If your student is utilizing crutches/wheelchair or wearing a boot/brace, the health office must be made aware with proper documentation on file in the health office.

- If your child had a physical or immunizations over the summer, please send a copy, or have your health care provider fax a copy, to school for their health file. All immunizations must be stamped or signed by a health care provider.

- Enclosed with this welcome letter are medical forms and if applicable, please complete and return to the health office by the first day of school.
  - **COVID Asthma Notice:** Please read if the student has asthma.
  - **Asthma Action Plan:** Please complete with your healthcare provider for any student that will have an inhaler in the health office.
  - **Anaphylaxis Plan:** Please complete with your healthcare provider for any student that will have epinephrine on campus (i.e. Epi Pen).
  - **Seizure Action Plan:** Please complete with your healthcare provider for any student that has a known seizure disorder.
  - **Diet Order:** Please complete with your healthcare provider for any student with a food allergy.
  - **Administration of Medication:** This form is required for any medication that will be in the health office. Please complete with your healthcare provider and provide one form per medication.

Do not hesitate to contact me if I can be of any assistance to advocate for your child's healthcare needs. I wish good health and a successful 2020-2021 school year for your student(s).

Sincerely,

Cyndi Stumer, DBH
Director of Health Services

Dear Parents/Guardians,

My name is Cyndi Stumer, and I am the Director of Health Services at Noah Webster Schools. I am writing you because your child, is a student at our school, and our records show they have asthma.

Children with asthma may be at high risk for complications from the new coronavirus, so keeping their asthma well-controlled is more important than ever. Asthma symptoms can happen anywhere, including during the school day or during before/after school activities.

Quick-relief ("rescue") asthma medicines (albuterol) should be available for your child to use at home, school and any other place your child may visit. We recommend students have a quick relief inhaler (metered dose-MDI), that is only for school use throughout the year, along with a written Asthma Action Plan that explains which medicines your child takes and how to manage symptoms. I have attached our school's approved Asthma Action Plan you can have your child's doctor fill out.

If you do not have an extra quick-relief inhaler on hand, please ask your doctor for a prescription for an extra inhaler to be stored at school. Please note that all medication must be picked up and dropped off by an adult through the front office with a valid prescription label intact, and a completed Administration of Medication Form completed, see attached. Due to the new coronavirus, nebulizers will not be used in our school unless absolutely necessary since they can spread the virus into the air.

Also, due to the new coronavirus, it would be best if your child also had their own spacer or valved holding chamber and peak flow meter at school so students do not have to share. Talk with your child's doctor and insurance company to make sure they will cover two devices: one for home and one for school.

Here is a list of what to ask your child's doctor to provide for this school year:
• An updated written Asthma Action Plan
• A quick-relief inhaler dedicated for school use only (also known as a metered dose inhaler or MDI)
• A spacer or valved holding chamber dedicated for school use
• A peak flow meter dedicated for school use

Contact NurseMesa@noahwebster.org or NursePima@noahwebster.org, if you are having difficulty getting any of these items on the list. Doctors' offices get very busy at the start of the school year, so the sooner you ask for these items, the easier it will be to get them. Having these items will help us manage your child's asthma while they are in school.

Sincerely,

Cyndi Stumer

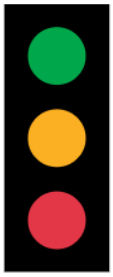
Cyndi Stumer, DBH

ASTHMA ACTION PLAN

Asthma and Allergy Foundation of America
aafa.org

Name:	Date:
Doctor:	Medical Record #:
Doctor's Phone #: Day	Night/Weekend
Emergency Contact:	
Doctor's Signature:	

The colors of a traffic light will help you use your asthma medicines.



GREEN means Go Zone!
Use preventive medicine.

YELLOW means Caution Zone!
Add quick-relief medicine.

RED means Danger Zone!
Get help from a doctor.

Personal Best Peak Flow: _____

GO

You have *all* of these:
- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can work & play

Peak flow:
from _____
to _____

Use these daily controller medicines:

MEDICINE	HOW MUCH	HOW OFTEN/WHEN
For asthma with exercise, take:		

CAUTION

You have *any* of these:
- First signs of a cold
- Exposure to known trigger
- Cough
- Mild wheeze
- Tight chest
- Coughing at night

Peak flow:
from _____
to _____

Continue with green zone medicine and add:

MEDICINE	HOW MUCH	HOW OFTEN/ WHEN

CALL YOUR ASTHMA CARE PROVIDER.

DANGER

Your asthma is getting worse fast:
- Medicine is not helping
- Breathing is hard & fast
- Nose opens wide
- Trouble speaking
- Ribs show (in children)

Peak flow:
reading below _____

Take these medicines and call your doctor now.

MEDICINE	HOW MUCH	HOW OFTEN/WHEN

GET HELP FROM A DOCTOR NOW! Your doctor will want to see you right away. It's important!
If you cannot contact your doctor, go directly to the emergency room. DO NOT WAIT.
Make an appointment with your asthma care provider within two days of an ER visit or hospitalization.

American Academy of Allergy Asthma & Immunology
www.aaaai.org

Anaphylaxis Emergency Action Plan

Patient Name: _____ **Age:** _____

Allergies: _____

Asthma ☐ **Yes** ***(high risk for severe reaction)*** ☐ **No**

Additional health problems besides anaphylaxis: _____

_____

Concurrent medications: _____

_____

Symptoms of Anaphylaxis

MOUTH	**itching, swelling of lips and/or tongue**
THROAT*	**itching, tightness/closure, hoarseness**
SKIN	**itching, hives, redness, swelling**
GUT	**vomiting, diarrhea, cramps**
LUNG*	**shortness of breath, cough, wheeze**
HEART*	**weak pulse, dizziness, passing out**

Only a few symptoms may be present. Severity of symptoms can change quickly.
Some symptoms can be life-threatening. ACT FAST!

Emergency Action Steps - DO NOT HESITATE TO GIVE EPINEPHRINE!

1. Inject epinephrine in thigh using (check one):

☐ **Adrenaclick (0.15 mg)** ☐ **Adrenaclick (0.3 mg)**

☐ **Auvi-Q (0.15 mg)** ☐ **Auvi-Q (0.3 mg)**

☐ **EpiPen Jr (0.15 mg)** ☐ **EpiPen (0.3 mg)**

Epinephrine Injection, USP Auto-injector- authorized generic
☐ **(0.15 mg)** ☐ **(0.3 mg)**

☐ **Other (0.15 mg)** ☐ **Other (0.3 mg)**

Specify others: _____

IMPORTANT: ASTHMA INHALERS AND/OR ANTIHISTAMINES CAN'T BE DEPENDED ON IN ANAPHYLAXIS.

2. Call 911 or rescue squad (before calling contact)

3. Emergency contact #1: home_____ **work**_____ **cell**_____

Emergency contact #2: home_____ **work**_____ **cell**_____

Emergency contact #3: home_____ **work**_____ **cell**_____

Comments: _____

_____

_____
Doctor's Signature/Date/Phone Number

_____
Parent's Signature (for individuals under age 18 yrs)/Date

SEIZURE ACTION PLAN (SAP)

EPILEPSY FOUNDATION | END EPILEPSY

Name: _____ Birth Date: _____

Address: _____ Phone: _____

Parent/Guardian: _____ Phone: _____

Emergency Contact/Relationship _____ Phone: _____

Seizure Information

Seizure Type	How Long It Lasts	How Often	What Happens

Protocol for seizure during school (check all that apply) ☑

- ☐ First aid – **Stay. Safe. Side.**
- ☐ Give rescue therapy according to SAP
- ☐ Notify parent/emergency contact
- ☐ Contact school nurse at _____
- ☐ Call 911 for transport to _____
- ☐ Other _____

First aid for any seizure

- ☐ **STAY** calm, keep calm, **begin timing seizure**
- ☐ Keep me **SAFE** – remove harmful objects, don't restrain, protect head
- ☐ **SIDE** – turn on side if not awake, keep airway clear, don't put objects in mouth
- ☐ **STAY** until recovered from seizure
- ☐ Swipe magnet for VNS
- ☐ Write down what happens _____
- ☐ Other _____

When to call 911

- ☐ Seizure with loss of consciousness longer than 5 minutes, not responding to rescue med if available
- ☐ Repeated seizures longer than 10 minutes, no recovery between them, not responding to rescue med if available
- ☐ Difficulty breathing after seizure
- ☐ Serious injury occurs or suspected, seizure in water

When to call your provider first

- ☐ Change in seizure type, number or pattern
- ☐ Person does not return to usual behavior (i.e., confused for a long period)
- ☐ First time seizure that stops on its' own
- ☐ Other medical problems or pregnancy need to be checked

When **rescue therapy** may be needed:

WHEN AND WHAT TO DO

If seizure (cluster, # or length) _____

Name of Med/Rx _____ How much to give (dose) _____

How to give _____

If seizure (cluster, # or length) _____

Name of Med/Rx _____ How much to give (dose) _____

How to give _____

If seizure (cluster, # or length) _____

Name of Med/Rx _____ How much to give (dose) _____

How to give _____

Care after seizure

What type of help is needed? (describe) _____

When is student able to resume usual activity? _____

Special instructions

First Responders: _____

_____

Emergency Department: _____

_____

Daily seizure medicine

Medicine Name	Total Daily Amount	Amount of Tab/Liquid	How Taken (time of each dose and how much)

Other information

Triggers: _____

Important Medical History _____

Allergies _____

Epilepsy Surgery (type, date, side effects) _____

Device: ☐ VNS ☐ RNS ☐ DBS Date Implanted _____

Diet Therapy ☐ Ketogenic ☐ Low Glycemic ☐ Modified Atkins ☐ Other (describe) _____

Special Instructions: _____

_____

Health care contacts

Epilepsy Provider: _____ Phone: _____

Primary Care: _____ Phone: _____

Preferred Hospital: _____ Phone: _____

Pharmacy: _____ Phone: _____

My signature _____ Date _____

Provider signature _____ Date _____

Epilepsy.com

Revised 01/2020 130SRP/PAB1216

EPILEPSY FOUNDATION | END EPILEPSY

Arizona Department of Education
Heath and Nutrition Services
School Nutrition Programs

DIET ORDER

Medical Statement for Student with Special Diet Needs

Part I (to be filled out by parent or guardian)

Name of Student: *(Last)* _____ *(First)*_____ *(MI)*_____

Social Security Number _____ – _____ – _____ Date of Birth _____/_____/_____ Age _____

School Attended by Student _____

Parent/Guardian's Daytime Phone Number(s) ( ) _____–_____ ( ) _____–_____

Name of Parent/Guardian(s)_____

Signature of Parent/Guardian _____

Part II (to be filled out by Physician)

Patient's Diagnosis _____

Describe the patient's condition and the major life activity affected by the condition related to the need for dietary modification:
_____
_____
_____

Indicate which dietary modification the patient needs and specify what changes need to be made:

□ Texture Modification: pureed □ ground □ chopped □ other _____
Specify Foods _____

□ Tube Feeding: Formula Name _____
Administering Instructions _____
Oral Feeding: □ No □ Yes If Yes, Specify Foods _____

Nutrient Modification: □ Increase Calories Description: _____
_____
_____
Supplement Name: _____

□ Decrease Calories Description: _____
_____
_____

□ Nutrient Restriction Description: _____
_____
_____

□ Special Mealtime Equipment: _____

□ Other: _____

Dietitian's Name *(if available)*: _____ Phone ( ) _____–_____

Physician: Name _____ Phone ( ) _____–_____

Address _____

PHYSICIAN SIGNATURE _____ Date _____

PURPOSE: To record the student's condition requiring dietary modifications of school lunch and the changes needed.

PREPARATION: The parent or guardian of the child is responsible for obtaining the form, filling out Part I, requesting completion by a physician, and delivering the form to the principal's office at the school attended by the child. A licensed physician is responsible for completing Part II of the document based on the child's medical condition. Consultation by a dietitian for completion of the form if needed should be requested by the parent or physician.

INSTRUCTIONS:

Part I (to be filled out by parent or guardian):

Name of Student: Enter the student's last name, first name, and middle initial.

Social Security Number: Enter the student's nine-digit social security number, e.g., ### – ## – #### .

Date of Birth: Enter the student's six-digit date of birth, e.g., May 21, 1988 = 05/21/88.

Age: Enter the student's one- or two-digit age as of the day the form is completed.

School Attended by Student: Enter the name of the school which the student regularly attends.

Parent/Guardian's Daytime Phone Number(s): If available, enter one or two telephone numbers with the area code where one or two of the guardians can be reached during the daytime.

Name of Parent/Guardian(s): Enter the full name of the student's parent(s) or legal guardian(s).

Signature of Parent/Guardian: Enter the signature of one parent or legal guardian's name. A printed name on the previous line should correspond to the signature.

Part II (to be filled out by physician):

Patient's Diagnosis: Insert the patient's clinical diagnosis for the condition which requires dietary modification.

Description of patient's condition and major life activity affected by the condition related to dietary modification: Describe the patient's condition as it affects a major life activity (i.e., caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working). Describe how the restrictions of the patient's condition affects his or her diet.

Indicate which dietary modification the patient needs and specify what changes need to be made: Check the type(s) of modification the patient's condition requires and fill in the corresponding specification next to the type of modification. A dietitian can assist in completing this section.

Dietitian's Name (if available): Provide a local dietitian's name and phone number if available.

Physician: Print the name, address, and phone number of the physician completing the form.

Physician Signature: Enter the signature of the physician filling out the form and the date signed.

Additional forms may be downloaded from the Arizona Department of Education website at:
www.ade.az.gov/health-safety/cnp/nslp/

Noah Webster Schools

REQUEST FOR IN-SCHOOL ADMINISTRATION OF PRESCRIPTION MEDICATION

NOTE TO PARENTS/GUARDIANS AND PHYSICIANS:

District personnel are not permitted to give medication of any kind (prescription and non-prescription) unless the student's parent or guardian authorizes, in writing, that the medication is needed. The parent's or guardian's authorization must be accompanied by written physician authorization for prescription medication. Medication must be delivered to the school with the label intact. The label on prescription medicine must include the student's name, date of expiration, and directions for use (i.e. dosage, when to consume, what, if anything to eat or drink when consuming).

If it is necessary that medication be administered while the student is at school, the following information must be provided:

Teacher:_____

Name of Child:_____

Birthdate:_____

Medication:_____

Strength of Medication_____

Reason Medication Prescribed_____

Route of administration (by mouth)_____

Dosage (amount to be given)_____

How often or at what time is medication to be given?_____

OTHER MEDICATION BEING TAKEN BY CHILD_____

_____

Contraindications with other medicines or food:_____

Storage instructions:_____

Date medications to be discontinued: _____

_____ **Phone No.**_____

Physician Signature

_____

Print Physician Name

If any changes in medication or dosage occur the school must be notified I immediately, and a new form must be completed. Students misuse of medication being self-administered may result in seizure and disciplinary action.

I request the administration of the medication indicated above. I give my consent for the School Nurse, health assistant or principal designee to administer this medication. I understand that I am responsible for maintaining an adequate supply of medication at the school to meet the child's need.

_____ **Home Phone No.**_____

Parent/Guardian Signature **Date**

_____ **Work Phone No.**_____

Print Parent/Guardian Name